Data on the Medicaid Program

Eligibility/Services/Expenditures 1979 Edition

THE HEALTH CARE FINANCING ADMINISTRATION

ERRATA SHEET

Replaces Page 41

TABLE 21.—FEDERAL, STATE AND LOCAL EXPENDITURES FOR MEDICAL ASSISTANCE, INCLUDING AMOUNTS NOT COMPUTABLE FOR FEDERAL MATCHING, FISCAL YEAR 1977

(in millions of dollars)

State	Total medical assistance payments [1]	Federal share	State share	Local share
Alabama	196.8	144.1	52.7	----
Alaska	18.2	10.4	7.8	----
Arizona [2]	----	----	----	----
Arkansas	150.3	110.1	40.2	----
California	2,618.0	1,104.0	1,241.0	373.0
Colorado	121.7	66.1	55.6	----
Connecticut	204.8	107.2	97.6	----
Delaware	22.2	12.0	10.2	----
District of Columbia	120.3	60.0	59.5	1.0[3]
Florida	239.6	133.4	106.2	----
Georgia	335.8	218.0	116.8	----
Guam	1.8	.9	.9	1.0
Hawaii	79.8	33.0	46.8	----
Idaho	33.3	24.0	9.3	----
Illinois	888.4	452.2	436.2	----
Indiana	239.3	135.0	104.3	----
Iowa	160.5	91.0	79.5	----
Kansas	164.5	81.4	85.1	----
Kentucky	185.2	136.2	49.0	----
Louisiana	220.4	167.6	52.8	----
Maine	89.1	67.1	22.0	----
Maryland	306.6	132.2	169.9	4.5
Massachusetts	781.4	385.0	396.4	----
Michigan	827.6	422.7	404.9	----
Minnesota	379.5	212.3	142.8	14.4
Mississippi	136.7	109.8	26.9	----
Missouri	188.3	109.1	79.2	----
Montana	43.0	26.8	16.2	----
Nebraska	68.4	40.2	16.4	11.9
Nevada	23.0	11.2	9.5	2.3
New Hampshire	46.0	27.4	18.6	----
New Jersey	481.1	236.3	244.8	[4]
New Mexico	47.5	34.6	12.9	----
New York	3,286.0	1,521.5	1,196.0	568.5
North Carolina	259.0	171.9	75.1	12.1
North Dakota	34.0	19.2	14.4	.4
Ohio	532.8	296.6	236.2	----
Oklahoma	207.7	139.6	68.1	----
Oregon	143.0	86.0	57.0	----
Pennsylvania	1,041.0	514.0	527.0	----
Puerto Rico	94.8	27.4	67.4	----
Rhode Island	102.6	62.0	40.6	----
South Carolina	146.6	105.0	41.6	----
South Dakota	32.7	21.8	10.9	----
Tennessee	224.2	160.6	63.6	----
Texas	716.2	430.2	260.0	----
Utah	44.9	37.5	7.4	----
Vermont	43.6	31.8	11.8	----
Virgin Islands	1.8	1.4	.4	----
Virginia	235.1	145.6	89.5	----
Washington	242.8	127.3	115.5	----
West Virginia	64.0	45.5	18.5	----
Wisconsin	505.0	312.3	192.7	----
Wyoming	7.7	5.0	2.7	----
Total	16,400.0	9,829.1	5,431.0	989.1

[1] Includes funds not computable for Federal matching. This accounts for the difference between this total and the total reported in Table 20. Payments not computable for Federal matching include expenditures to provide medical assistance to (a) persons who are financially eligible but not a member of one of the eligible categories of persons covered under the law (that is, they are persons between the ages of 21 and 65 who are not blind or disabled or AFDC parents) or (b) people whose income exceeds the income standards established in the State plan or the maximum level allowed for the medically needy by the Federal law.

[2] No Title XIX program in effect.

[3] Local funding represents money collected from local taxes rather than Congressional appropriations.

[4] Required local contribution in New Jersey is to administrative cost of the program; no amount reported as medical assistance payments.

Source: State expenditure data.

DATA ON THE MEDICAID PROGRAM: ELIGIBILITY, SERVICES, EXPENDITURES

1979 EDITION

Medicaid/Medicare Management Institute

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Health Care Financing Administration
Baltimore, MD 21235
1979

FOREWORD

This newest edition of *Data on the Medicaid Program* was updated by the Health Care Financing Administration, and represents the most comprehensive compilation of Medicaid data available.

The Medicaid program, Title XIX of the Social Security Act, is administered by the States under Federal guidelines, and is jointly funded by State and local governments and the Department of Health, Education, and Welfare. On the Federal level, Medicaid is the responsibility of the Health Care Financing Administration.

Acknowledgements are given to Medicaid staffers Ron Hester, Nola Petrovich, Lillie Taylor, Ginger Hale, Chuck Owens, and Mickey McManus for their efforts. This publication should serve as a valuable source document to those interested in the Medicaid program and the delivery of health care services.

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CONTENTS

DATA ON THE MEDICAID PROGRAM: ELIGIBILITY, SERVICES, EXPENDITURES—

Introduction

Title XIX of the Social Security Act provides for a program of medical assistance for certain low-income individuals and families. The program, known as Medicaid, became Federal law in 1965. It succeeded earlier welfare-linked medical care programs, most notably the Kerr-Mills program of medical assistance for the aged. Medicaid will account for some $19 billion in Federal and State expenditures in FY 1979, and is the primary source of health care coverage for the poor in America.

Medicaid is financed jointly with State and Federal funds, with the current Federal contribution to the cost of the program ranging from 50 percent to 77.55 percent. It is basically administered by each State within certain broad Federal requirements and guidelines.

Medicaid is designed to provide medical assistance to those groups or categories of people who are eligible to receive cash payments under one of the existing welfare programs established under the Social Security Act; that is, Title IV-A, the program of Aid to Families with Dependent Children (AFDC), or Title XVI, the Supplemental Security Income (SSI) program for the aged, blind and disabled. In general, receipt of a welfare payment under one of these programs means automatic eligibility for Medicaid (although since 1974, when the welfare programs for the aged, blind and disabled were Federalized as the SSI program, States may exclude some of these SSI cash assistance recipients from automatic Medicaid eligibility if they are eligible only because the standards for the Federal program are more liberal than those previously utilized by the State.)

In addition, States may provide Medicaid to the "medically needy," that is, to people who fit into one of the categories of people covered by the cash welfare programs (aged, blind, or disabled individuals, or members of families with dependent children when one parent is absent, incapacitated or unemployed), who have enough income to pay for their basic living expenses (and so are not recipients of welfare) but not enough to pay for their medical care.

It is important to note that Medicaid does not provide medical assistance to all of the poor. Low income is only one test of eligibility. Resources are also tested. And most importantly one must belong to one of the groups designated for welfare eligibility to be covered.

Title XIX of the Social Security Act requires that certain basic services must be offered in any State Medicaid program: inpatient hospital services, outpatient hospital services, laboratory and X-ray

services, skilled nursing facility services for individuals 21 and older, home health care services for individuals eligible for skilled nursing services, physicians' services, family planning services, rural health clinic services, and early and periodic screening, diagnosis and treatment services for individuals under 21. In addition, States may provide a number of other services if they elect to do so, including drugs, eyeglasses, private duty nursing, intermediate care facility services, inpatient psychiatric care for the aged and persons under 21, physical therapy, dental care, etc.

States determine the scope of services offered (they may limit the days of hospital care or number of physicians' visits covered, for example.) They also, in general, determine the reimbursement rate for services, except for hospital care, where States are required to follow the Medicare reasonable cost payment system unless they have approval from the Secretary of Health, Education, and Welfare to use an alternate payment system for hospital care. Since July 1, 1976, they have been required to reimburse for skilled nursing facility and intermediate care facility services on a reasonable cost-related basis.

Since States generally determine the eligibility level for the welfare programs (they set the AFDC level, and determine the amount of supplement, if any, to the basic Federal SSI payment), they exercise a great deal of control over the income eligibility levels for Medicaid. If they cover the medically needy, they may establish the income level for eligibility at any point between the cash assistance eligibility level for an AFDC family (adjusted for family size) and 133⅓ percent of the payment to such an AFDC family. All of these variations—in benefits offered, in groups covered, in income standards, and in levels of reimbursement for providers—mean that Medicaid programs differ greatly from State to State.

Medicaid operates as a vendor payment program. Payments are made directly to the provider of service for care rendered to an eligible individual. Providers must accept the Medicaid reimbursement level as payment in full. Individuals, however, are required to turn over their excess income to help pay for their care if they are in a nursing home Copayments may also be required.

Many members of the Medicaid population are aged or disabled and are also covered under Medicare. In cases where this dual coverage exists, most State Medicaid programs pay for the Medicare premiums, deductibles and copayments, and for services not covered by Medicare.

States participate in the Medicaid program at their option. All States except Arizona currently have Medicaid programs. The District of Columbia, Puerto Rico, Guam and the Virgin Islands also provide Medicaid coverage.

Technical Note

Expenditure totals vary among the tables in the report because data on the Medicaid program are collected on three basic types of reports.

(1) Actual expenditure data are reported on financial expenditure reports, which are collected by the Office of Financial Management in HCFA, and reflect actual Federal, State and local expenditures for each State. For FY 1977 and earlier, these data were compiled by the Division of Finance in the Social and Rehabilitation Service. These reports are generally available 6 months following the close of the fiscal year, and are the basis for the figures on actual expenditures that appear in the President's Budget. Future year budget expenditures are projected figures based primarily on quarterly estimates provided by the States, which are then adjusted by HEW.

(2) Monthly statistical reports compile State data on recipients and on Medicaid expenditures. In both cases, data are presented by money-payment status and basis of eligibility. In addition, expenditure data are provided by type of medical service. No linkage is available in the monthly data between expenditures by type of service and the recipient characteristics.

(3) Annual statistical reports compile detailed State data on expenditures and recipients by money-payment status and basis of eligibility, type of service, and age and sex of recipient.

I. General Information on Medicaid Coverage and Services

The first section of this report (Tables 1-8) examines the services covered under the State Medicaid programs, including the required services, optional services, and limitations in the scope of coverage; cost-sharing requirements; recent changes in State Medicaid programs; methods of reimbursement for selected Medicaid services; and the persons covered under Medicaid.

A. MEDICAID SERVICES STATE-BY-STATE

Certain services must be covered under a State's Medicaid program, although the scope of coverage may be limited as noted below. These basic required services are:

Inpatient hospital care;
Outpatient hospital care and rural health clinic services;
Other laboratory and X-ray services;
Skilled nursing facility services and home health services for individuals 21 years of age and over;
Early and periodic screening, diagnosis, and treatment (EPSDT) for individuals under 21 years of age;
Family planning services; and
Physician services.

States may include additional services as well. Table 1 lists a number of the optional services which can be covered under State Medicaid programs, and shows which States cover them. In addition, States can, with the approval of the Secretary, cover any other medical service recognized under State law.

B. LIMITATIONS ON SELECTED SERVICES

States can impose limitations on their coverage of both mandatory and optional services, such as limitations on the number of days of care for inpatient services, and limitations on the number of outpatient visits. In addition, States can require prior authorization for certain services. Table 2 details limitations for four major services: inpatient hospital services, skilled nursing facility services, intermediate care facility services, and physician services.

C. MEDICARE-MEDICAID RELATIONSHIPS

Many persons are covered under both the Medicare and Medicaid programs. Medicare covers both inpatient hospital and supplementary medical services. However, while coverage of inpatient hospital services (Part A of Medicare) is automatic for persons over 65 and certain

disabled persons who have insured status under the Social Security system, coverage for the supplementary medical insurance program (Part B of Medicare) requires payment of a monthly premium. Many States make this payment for their Medicaid eligibles who are also eligible for Medicare. These "buy-in" agreements between State Medicaid programs and the Social Security Administration allow Medicare coverage for those Medicaid-Medicare eligibles who might not be able to afford to pay the Part B premium on their own. When persons are eligible under both programs, Medicare makes the primary payment for the service, and the State Medicaid expenditure is limited to the deductible and co-payment amounts.

While States may buy-in to Medicare for both their cash assistance recipients and medically needy persons who are eligible for Medicare, they receive Federal matching payments on the amounts paid for Medicare premiums only for their cash assistance recipients: they must pay the full cost of the premium payments for the medically needy. If a State does not buy-in to Part B coverage for persons in their Medicaid program who are eligible under Medicare, it cannot receive Federal matching payments for expenditures for services that would have been covered under Medicare if there had been a buy-in arrangement.

Forty-eight States and jurisdictions have buy-in agreements with the Social Security Administration; 5 States and jurisdictions do not (Table 3.) Based on statistically reported data for FY 1975, there were 3.7 million aged Medicaid recipients. Approximately 50 percent of the total Medicaid aged population had payments made in their behalf for deductibles and coinsurance under buy-in agreements.

Besides paying premiums, deductibles and copayments for many persons who are eligible for Medicare, State Medicaid programs also provide many services for the elderly and disabled that are not provided by Medicare (for example, skilled nursing care beyond the 100-day posthospital benefit provided by Medicare, prescription drugs, eyeglasses, hearing aids, etc.). Expenditures for the elderly under Medicaid basically supplement Medicare coverage.

TABLE 1

MEDICAID SERVICES STATE BY STATE,

DECEMBER 1, 1977 1/

* BASIC REQUIRED MEDICAID SERVICES Every Medicaid program must cover at least these services for at least everyone receiving federally supported financial assistance: inpatient hospital care; outpatient hospital services; other laboratory and X-ray services; skilled nursing facility services and home health services for individuals 21 and older; early and periodic screening, diagnosis, and treatment for individuals under 21; family planning; and physician services. Federal financial participation is also available to States electing to expand their Medicaid programs by covering additional services and/or by including people eligible for medical but not for financial assistance. For the latter group States may offer the services required for financial assistance recipients or may substitute a combination of seven services.

Services provided only under the Medicare buy-in or the screening and treatment program for individuals under 21 are not shown on this chart.

Definitions and limitations on eligibility and services vary from State to State. Details are available from local welfare offices and State Medicaid agencies.

● offered for people receiving federally supported financial assistance

✚ offered also for people in public assistance 2/ and SSI 3/ categories who are financially eligible for medical but not for financial assistance

FMAP 4/	BASIC* REQUIRED MEDICAID SERVICES/ SEE ABOVE		Additional services for which Federal financial participation is available to States under Medicaid: Clinic services	Prescribed drugs	Dental services	Prosthetic devices	Eyeglasses	Private duty nursing	Physical therapy and related services	Other diagnostic, screening, preventive, and rehabilitative services	Emergency hospital services	Skilled nursing facility services for patients under 21	Optometrists' services	Podiatrists' services	Chiropractors' services	Care for patients 65 or older in institutions for mental diseases	Care for patients 65 or older in institutions for tuberculosis	Care for patients under 21 in psychiatric hospitals	Institutional services in intermediate care facilities	
73	●	Alabama		●		●	●				●	●	●				●	●	● 3/	AL
50	●	Alaska	●				●				●	●	●			●		●	● 3/	AK
61		Arizona																		AZ
72	✚	Arkansas	✚	✚	✚	✚	✚				✚	●	✚		✚	✚	✚	✚	● 3/	AR
50	✚	California	✚	✚	✚	✚	✚		✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚ 3/	CA
54	●	Colorado		●		●		●			●	●		●		●		●	● 3/	CO
50	✚	Connecticut	✚	✚	✚	✚	✚	✚	✚	✚		✚	✚	✚	✚	✚		✚	✚ 3/	CT
50	●	Delaware	●	●				●						●		●		●	● 3/	DE
50	✚	D.C.	✚	✚		✚	✚		✚	✚	✚	✚	✚	✚		✚	✚	✚	✚ 3/	DC
57	●	Florida		●							●					●	●	●	● 3/	FL
66	●	Georgia	●	●		●						●		●		●	●		● 3/	GA
50	✚	Guam	✚	✚	✚	✚	✚		✚		✚	✚	✚							GU
50	✚	Hawaii	✚	✚	✚	✚	✚		✚	✚	✚	✚	✚						✚	HI
64	●	Idaho	●	●							●	●	●	●	●				● 3/	ID
50	✚	Illinois	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚ 3/	IL
58	●	Indiana	●	●	●	●	●	●	●	●	●	●	●	●	●			●	● 3/	IN
52	●	Iowa		●	●	●	●		●	●	●	●	●	●	●				● 3/	IA
52	✚	Kansas	✚	✚	✚	✚	✚	✚	✚		✚	✚	✚	✚	✚	✚	✚	✚	✚ 3/	KS
70	✚	Kentucky	✚	✚	✚	✚			✚		✚	✚				✚	✚	✚	✚ 3/	KY
70	✚	Louisiana	✚	✚		✚					✚	●			✚	●	●	●	● 3/	LA
70	✚	Maine	●	✚		✚			✚	✚	●	✚		✚	✚	✚		✚	● 3/	ME
50	✚	Maryland	✚	✚		✚	✚				✚	✚	✚	✚		✚	✚		● 3/	MD
52	✚	Massachusetts	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚		✚ 3/	MA
50	✚	Michigan	✚	✚	✚	✚	✚		✚		✚	✚	✚	✚	✚	✚		✚	✚ 3/	MI
55	✚	Minnesota	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚ 3/	MN
78	●	Mississippi		●	●							●			●	●			● 3/	MS
61	●	Missouri		●	●				●				●		●	●			● 3/	MO
61	✚	Montana	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚		✚		✚	✚ 3/	MT
53	✚	Nebraska	✚	✚	✚	✚	✚	✚	✚		✚	✚	✚	✚	✚	✚	✚		✚ 3/	NB
50	●	Nevada	●	●	●	●	●	●	●		●	●	●	●	●				●	NV
63	✚	New Hampshire	✚	✚		✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚			● 3/	NH
50	●	New Jersey	●	●	●	●	●		●	●	●	●	●	●	●	●	●	●	● 3/	NJ
72	●	New Mexico	●	●	●	●	●	●	●		●	●	●	●					● 3/	NM
50	✚	New York	✚	✚	✚	✚	✚		✚	✚	✚	✚	✚			✚	✚	✚	✚ 3/	NY
68	✚	North Carolina	✚	✚			✚			✚		✚	✚	✚	✚	✚	✚	✚	✚ 3/	NC
51	✚	North Dakota		✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚			✚	✚	ND
55	●	Ohio	●	●	●	●	●	●	●		●	●	●	●	●	●		●	● 3/	OH
65	✚	Oklahoma		✚	✚	✚								✚		✚		✚	✚ 3/	OK
57	●	Oregon	●	●	●	●	●	●		●	●	●	●	●	●	●		●	● 3/	OR
55	✚	Pennsylvania	✚	●	●	●					✚	✚	✚	●	✚	✚		✚	✚ 3/	PA
50	✚	Puerto Rico	✚	✚	✚			✚	✚	✚	✚						✚			PR
57	✚	Rhode Island		✚	✚	✚	✚					✚	✚	✚		✚			● 3/	RI
72	●	South Carolina	●	●	●	●					●	●			●	●	●	●	● 3/	SC
64	●	South Dakota	●	●	●	●			●		●	●			●				● 3/	SD
69	✚	Tennessee	✚	✚		✚					✚					✚	✚	✚	✚ 3/	TN
61	●	Texas		●		●	●				●		●	●	●		●		● 3/	TX
69	✚	Utah	✚	✚	✚	✚	✚	✚	✚		✚	✚	✚	✚	✚			✚	✚ 3/	UT
68	✚	Vermont	✚	✚		✚					✚	✚			✚			✚	✚	VT
50	✚	Virgin Islands	✚	✚	✚	✚	✚													VI
57	✚	Virginia	✚	✚			✚		✚		✚	✚	✚	✚		✚	✚		✚ 3/	VA
52	✚	Washington	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚ 3/	WA
70	✚	West Virginia	✚	✚		✚	✚	✚	✚			✚	✚	✚	✚	✚			✚	WV
59	✚	Wisconsin	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚ 3/	WI
53	●	Wyoming										●	●						●	WY
● 20	●		13	19	12	14	10	5	9	4	17	18	13	13	10	13	9	11	26	
✚ 33	✚		29	32	22	29	25	13	23	16	26	26	25	23	18	28	18	21	24	
53		Total	42	51	34	43	35	18	32	20	43	44	38	36	28	41	27	32	50	

Intermediate Care Facilities (ICF): P.L. 92-223 transferred the ICF program to Medicaid (Title XIX) as an optional service, effective 1-1-72. States may at their option include institutions for the mentally retarded, both public and private. See footnote five.

1/ Data from Regional Office reports of characteristics to State programs and State plan amendments.
2/ People qualifying as members of families with dependent children (usually families with at least one parent absent or incapacitated).
3/ People qualifying as aged, blind, or disabled under the Supplemental Security Income program.
4/ FMAP - Federal Medicaid Assistance Percentage: Rate of Federal financial participation in a State's medical vendor payment expenditures on behalf of individuals and families eligible under Title XIX of the Social Security Act. Percentages, effective from October 1, 1977, through September 30, 1979, are rounded.
5/ Including ICF services in institutions for the mentally retarded.

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE — Health Care Financing Administration — Medicaid Bureau
Division of State Management
(HCFA)-77-801*

TABLE 2.—LIMITATIONS ON SELECTED SERVICES OFFERED UNDER TITLE XIX, JANUARY, 1979

State	Inpatient Hospital Services	Skilled Nursing Facility Services	Intermediate Care Facility Services	Physicians' Services
Alabama	20 days per calendar year	Preauthorization required	Preauthorization required	Prior authorization required, 1 visit per month outside hospital for chronic stable illness; 1 visit per day in hospital.
Alaska	Nonemergency out-of-State hospitalization requires preauthorization.	Preauthorization required	Preauthorization required	Elective (cosmetic) surgery requires preauthorization.
Arkansas	Limited to 26 days per calendar year with provision for extension based on medical necessity and with prior authorization.	Prior authorization required	No limitations	18 visits per calendar year in physician's office, patient's home or nursing home. For hospital emergency room visits, 12 per calendar year.
California	Subject to prior authorization and specified length of stay as approved.	Subject to preadmission authorization and periodic reauthorization.	Subject to preadmission authorization and periodic reauthorization.	Subject to prior authorization for more than eight psychiatric visits or eight allergy hyposensitization visits in a 120-day period. Services for cosmetic purpose not covered. Prior authorization required for sterilization services.
Colorado	Services provided as long as is medically necessary. Emergency hospital services provided when necessary to prevent death or serious impairment of health, even though hospital may not meet conditions for participation under Title XVIII.	No limitations	No limitations	No limitations.
Connecticut	Prior authorization is required beyond 10 days.	Initial review to determine level of care made by a medical consultant within 14 days of patient's admission to a facility. Periodic patient reviews are made thereafter by a team to determine need for skilled nursing services.	Level of care is determined within 14 days of patient's admission to facility and the need for continued care in the facility is periodically redetermined thereafter.	Prior authorization required for services to patients in skilled nursing facilities beyond 1 visit per month for chronic conditions and 5 visits per month for acute conditions.
Delaware	No limitations	No limitations	No limitations	No limitations.

TABLE 2.—LIMITATIONS ON SELECTED SERVICES OFFERED UNDER TITLE XIX—Continued

State	Inpatient Hospital Services	Skilled Nursing Facility Services	Intermediate Care Facility Services	Physicians' Services
District of Columbia	Services provided in connection with surgical procedures for cosmetic purposes (except for emergency repair of accidental injury) will be included only by prior authorization issued by State agency, services provided in connection with dental or oral surgery will be limited to those required for emergency repair of accidental injury to jaw and related structures.	Items and services furnished by skilled nursing facilities maintained primarily for care and treatment of inpatients with TB will be provided only for individuals 65 years of age or older.	No limitations	Elective procedures requiring general anesthesia will be provided only when performed in a facility accredited for such procedures. Surgical procedures for cosmetic purposes (except for emergency repair of accidental injury) will be provided only by prior authorization issued by State agency. Ambulatory psychiatric care will be provided only in a formally organized psychiatric clinic which is approved as such by State agency, except when prior authorization for such care has been obtained from State agency.
Florida	45 days per patient per Fiscal Year	No limitations	No limitations	Excludes routine physicals and eye examinations, internal organ transplants which are considered experimental, clinically unproven procedures, and sterilization procedures for any person who has been judicially declared mentally incompetent, or who is under age 21, or who is legally incompetent under State law.
Georgia	Prior approval required for renal dialysis and/or kidney transplants except in cases of emergency dialysis which require a notation on claim form that such treatment was an emergency.	Initial prior approval is required	Initial prior approval is required	Outpatient psychotherapy is limited to maximum of $250 per patient per calendar year. Unless medically justifiable need for exception exists, home and office visits limited to 1 per month, nursing home visits limited to 1 per month, and hospital visits limited to 1 per day.
Guam	A Medicaid recipient may not be confined for more than 65 consecutive days at a semi-private rate. If confinement is medically necessary after this period of time, then a reduced room rate equal to a SNF must be utilized. Only first 3 pints of blood. One doctor visit per day except for intensive care or consultation.	Limited to 3 routine Doctor's visits per month. Cost and limitations as outlined in Title XVIII.	Not provided	2 visits per week in SNF. Transportation cost of physician not covered.

Hawaii	Hospital admissions are authorized for following number of days: Medical and surgical—8 days. Confinement and delivery—4 days. T. & A.—2 days. Psychiatric—10 days. Prior authorization is required for any non-emergency admission such as for elective surgery; approval for extension is required for additional days.	Prior authorization required	Prior authorization required	For patients in skilled nursing facilities limited to 2 visits per month except during acute episodes when additional vistis are authorized.
Idaho	Limited to 40 days per admission. Length of stay subject to professional review for appropriateness and necessity, but will not exceed forty days per admission.	Prior authorization is required before payment.	Prior authorization is required before payment.	Physician services related to abortion or abortion related services will not be provided unless the abortion or abortion related services are recommended by 2 consulting physicians who state that it is necessary to save the life of the mother, 2 consulting physicians' recommendations that the mother will suffer severe and long lasting physical health damage if the fetus is carried to term; that in the case of rape or incest, the incident is reported promptly to a law enforcement agency or public health agency and the pregnancy is a result of rape or incest as determined by the court.
Illinois	Psychiatric services limited to an initial period of 10 days and a possible 10 day extenson with prior approval. There is a maximum of 45 inpatient days per year.	No limitations	No limitations	No limitations.
Indiana	No limitations	No Imitations	No limitations	No limitations.
Iowa	No limitations	No limitations	No limitations	No limitations.

TABLE 2.—LIMITATIONS ON SELECTED SERVICES OFFERED UNDER TITLE XIX—Continued

State	Inpatient Hospital Services	Skilled Nursing Facility Services	Intermediate Care Facility Services	Physicians' Services
Kansas	All out-of-State inpatient care is subject to prior authorization except for emergency care and care within hospitals bordering Kansas, whose services are routinely utilized by Kansas recipients. No payment will be made for inpatient admissions from midnight Thursday through midnight Saturday except in the case of an emergency admission.	No limitations	No limitations	Office calls are limited to 3 per month unless supported by written documentation confirming medical necessity. Adult care home visits are limited to 1 per month unless supported by written documentation confirming medical necessity. Surgery for cosmetic purposes is not available. Abortions are provided when necessary because the life of the mother is endangered if the fetus is carried to term, or when performed upon a victim of rape or incest and it has been reported to appropriate authorities within 60 days of the incident.
Kentucky	21 days per admission	Preauthorization required	Preauthorization required	Initial and extensive visits limited to 2 per patient per physician per calendar year. Preauthorization required for those patients "locked in" to 1 physician and 1 pharmacy, who require services in excess of 4 prescriptions and 4 physician office visits per month.
Louisiana	Care in a short term general hospital is limited to 15 days in a calendar year without prior approval. If a recipient requires hospitalization beyond 15 days, or readmission, a determination to extend hospitalization would be made.	No limitations	No limitations	Limited to 12 outpatient visits per year, with extensions subject to prior approval. Up to 15 inpatient visits including admission visits in any calendar year when recipient is hospitalized without surgery.
Maine	Prior authorization required for extension of hospital benefit days beyond 60 days. Intensive care and coronary care services do not require prior authorization.	No limitations	No limitations	No limitations.
Maryland	Preauthorization required	Preauthorization required for all admissions.	Preauthorization required for all admissions.	Preauthorization required for surgery normally considered cosmetic.

Massachusetts	No limitations	No limitations	No limitations	Preauthorization required.
Michigan	Minimum period necessary in type of facility for the proper care and treatment of patient.	Minimum period necessary in type of facility for the proper care and treatment of patient.	Provided based on level of care appropriate to patient's medical needs.	Visits in the nursing home setting are limited to 1 visit per patient per month; additional visits must be documented as medically necessary.
Minnesota	No limitations	No limitations	No limitations	No limitations.
Mississippi	40 days per Fiscal Year	Prior authorization required	Prior authorization required	Hospital visits—limited to 1 per day; nursing home visits—limited to 36 per Fiscal Year.
Missouri	21 days per admission	Prior authorization required	Prior authorization required	Limited to those that are medically necessary. Payment is not made for cosmetic surgery. Certain recipients who have over-utilized physician's services are limited to service of only 1 physician of their own choosing.
Montana	No limitations	No limitations	No limitations	No limitations.
Nebraska	Prior authorization required	No limitations	No limitations	No specified limitations.
Nevada	Limited to admissions designated in the Concurrent Review Screening manual.	Prior authorization required	Prior authorization required	Limited to 2 office visits per person per month for treatment of illness, 2 therapeutic injections per month and emergency treatment. Services to hospital inpatients are not limited.
New Hampshire	Requires prior approval for patients who are anticipated to require hospitalization for period longer than 12 days.	Prior authorization required	Prior authorization required	Limited to 1 visit per month per patient, except 1 visit per week for acute care SNF patients.
New Jersey	Limited by exclusion of elective cosmetic surgery and diet therapy for exogenous obesity.	Prior authorization required except where patient is transferred to nursing home directly from an acute care facility.	Prior authorization required	Prior authorization required for elective cosmetic surgery and for psychiatric treatment when costs exceed $300 in given year.
New Mexico	Abortions are provided under certain conditions.	No limitations	No limitations	Abortions are provided under certain conditions.
New York	No limitations	Prior approval except when admitted directly from hospital, another nursing home, or from health related facility.	No limitations	No limitations.

TABLE 2.—LIMITATIONS ON SELECTED SERVICES OFFERED UNDER TITLE XIX—Continued

State	Inpatient Hospital Services	Skilled Nursing Facility Services	Intermediate Care Facility Services	Physicians' Services
North Carolina	Prior authorization required for admissions for cosmetic surgery and surgical transplants except bone, tendon and renal transplants.	Prior approval required	Prior authorization required	Routine physical exams and routine screening tests are excluded except for EPSDT recipients and an annual examination allowed for recipients in homes for aged, skilled nursing and intermediate care facilities. Eye refractions are limited to 1 per year for recipients ages 24 and under, and 1 in 2 years for recipients ages 25 and over. Prior approval required for surgical transplants (except for bone, renal and tendon),, cosmetic surgery and more than 2 psychiatric visits.
North Dakota	No limitations	No limitations	No limitations	No limitations.
Ohio	60-day limitation per spell of illness	Physicians' certification and recertification required every 60 days.	No limitations. Persons must be in need of such care.	10 physician visits per month.
Oklahoma	10 days per admission	Prior approval required	Preauthorization required	Limited to inpatient hospital visits and surgical services for a compensable hospital period; outpatient-4 office visits and/or 4 home visits per month per patient; and 2 visits per month in a nursing home.
Oregon	Limited to 21 days	No limitations	No limitations	Prior authorization required for elective and rehabilitative procedures.
Pennsylvania	Payment is not made for overnight or weekend passes in excess of 12 hours continuous absence and absence for purposes of employment or school. Payment is not made for prolonged hospitalization which is not medically justified.	No limitations	No limitations	Prior authorization required for all general and special medical examinations and consultations. Hospital inpatients—consultations limited to 1 per specialty per hospital admission; outpatient—consultation limited to 1 per 12 month period. $200 maximum amount payable to physician for his services provided during any 1 period of hospitalization or for a series of recurrent or related surgical procedures.

Puerto Rico	Limited to services provided in public facilities and 2 private facltes under contract.	Provided in public facilities	Not provided	Available through public facilities and some physicians under contract.
Rhode Island	Prior authorization required for stays in excess of 15 days per admission for persons under age 65, or in excess of 60 days for persons age 65 or older who are also covered by Medicare.	Prior authorization required for all admissions.	No limitations	Prior authorization required for visits in excess of 2 per month for chronic illness and in excess of 8 per month for acute illness; inpatient hospital visits in excess of 37 days up to maximum of 100 days, office visits provided by psychiatrists beyond initial evaluation visit.
South Carolina	40 days per Fiscal Year	Need for care approved or disapproved by State office.	Need for care approved or disapproved by State office.	Must be medically justified.
South Dakota	30 days per benefit period. 1st 3 pints of blood per benefit period.	No limitations	No limitations	Limited to services which are medically necessary and required by patient.
Tennessee	20 days per Fiscal Year	Prior authorization required	No limitations	Prior approval required for unusual elective types of surgical procedures.
Texas	30 days per spell of illness	Level of care determination is required	Level of care determination is required	No limitations.
Utah	No limitations	No limitations	No limitations	No limitations on number of visits for acute conditions, except psychiatric care is limited to 12 hours of treatment for each acute illness unless prior written approval for additional care is obtained.
Vermont	No specified day limitations	Authorization is required	Authorization is required	Treatment of mental, psychoneurotic or personality disorders limited to $500 per calendar year.
Virgin Islands	Prior authorization required	Service presently being developed. Prior authorization will be required.	Not provided	Limited to services provided by Health Department personnel; otherwise by prior authorization of the Bureau.

TABLE 2.—LIMITATIONS ON SELECTED SERVICES OFFERED UNDER TITLE XIX—Continued

State	Inpatient Hospital Services	Skilled Nursing Facility Services	Intermediate Care Facility Services	Physicians' Services
Virginia	14 days per admission	No limitations	No limitations	Cosmetic surgical procedures are not covered unless performed for physiological reasons. Routine physicals and immunizations are not covered except that well-child examinations in a private physician's office are covered for foster children. Prior authorization is required for refraction and eyeglasses. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment of health to the mother if the fetus were carried to term. Substantial endangerment of health includes endangerment of the life of the mother.
Washington	Approval for admission required	Prior approval of admission	No limitations	1 visit per month in office, home, skilled nursing facility, intermediate care faciiity for nonemergency conditions. 2 per month in extended care facility. 1 per day in hospital, additional calls must be justified.
West Virginia	60 days per Fiscal Year	Prior approval of admission	Prior approval required	No limitations.
Wisconsin	Prior authorization is required for cosmetic surgery, intestinal or gastric bypass surgery and reversal of a tubal ligation or vasectomy.	Prior authorization required	Prior authorization required	Prior authorization is required for cosmetic surgery, intestinal or gastric bypass surgery and reversal of a tubal ligation or vasectomy.
Wyoming	14 days per spell of illness	No limitations	No limitations	Physical examinations limited to 1 yearly after 3rd year of life; nursing home visits limited to 1 routine visit per month.

TABLE 3.—STATE BUY-IN ARRANGEMENTS WITH MEDICARE

	State pays part B premiums for persons eligible for Medicare and Medicaid	State does not buy in to Part B of Medicare
Alabama	X	
Alaska		X
Arizona [1]	X	
Arkansas	X	
California	X	
Colorado	X	
Connecticut	X	
Delaware	X	
District of Columbia	X	
Florida	X	
Georgia	X	
Guam	X	
Hawaii	X	
Idaho	X	
Illinois	X	
Indiana	X	
Iowa	X	
Kansas	X	
Kentucky	X	
Louisiana		X
Maine	X	
Maryland	X	
Massachusetts	X	
Michigan	X	
Minnesota	X	
Mississippi	X	
Missouri	X	
Montana	X	
Nebraska	X	
Nevada	X	
New Hampshire	X	
New Jersey	X	
New Mexico	X	
New York	X	
North Carolina	X	
North Dakota	X	
Ohio	X	
Oklahoma	X	
Oregon		X
Pennsylvania	X	
Puerto Rico		X
Rhode Island	X	
South Carolina	X	
South Dakota	X	
Tennessee	X	
Texas	X	
Utah	X	
Vermont	X	
Virgin Islands	X	
Virginia	X	
Washington	X	
West Virginia	X	
Wisconsin	X	
Wyoming		X

[1] No Medicaid program.

Source: Medicaid Bureau, April 1979.

D. COST-SHARING FEATURES OF STATE MEDICAID PROGRAMS

As a result of the Social Security Amendments of 1972 (PL 92-603), States may impose certain cost-sharing requirements under their Medicaid program. The law specifies that no cost sharing can be imposed on the mandatory services for cash assistance recipients, but allows States to impose "nominal" cost-sharing requirements on optional services for cash assistance recipients, and on any services for the medically needy. Table 4 details the cost-sharing requirements which have been imposed by the States as a result of this legislation.

It should be noted that all States require Medicaid patients in long term care institutions to contribute their excess income (generally, all income over the $25 monthly they require for personal needs) to help pay for the cost of their care. Similarly, all medically needy individuals who have income that exceeds the amount set for Medicaid eligibility must use their excess income to pay for their medical care until they have spent their income down to the Medicaid level. Neither of these forms of paying for one's own medical care is subject to the limitations on cost-sharing in the Medicaid program, and they are not indicated in Table 4.

Table 4.—COST-SHARING FEATURES OF STATE MEDICAID PROGRAMS

ALABAMA.—Prescription drugs—copayment of $.50 per prescription and refills.

ARKANSAS.—Prescription drugs—copayment of $.50 per prescription.

DISTRICT OF COLUMBIA.—Prescription drugs—copayment of $.50 per prescription. Copayment of $2.00 on eyeglasses not provided as a part of an integrated program of medical services.

GEORGIA.—Prescription drugs—copayment of $.50 per prescription. Copayments also imposed on ambulance services, durable medical equipmeent and orthotic and prosthetic services. The copayments for these services are: $.50 on $10 or less; $1.00 on $11 to $25; $2.00 on $26 to $50; $3.00 on $51 or more based on sliding fees.

KANSAS.—Prescription drugs—copayment of $.50 per each prescription, new and refills.

MARYLAND.—Prescription drugs—copayment of $.50 per prescription.

MICHIGAN.—Vision services provided to recipients over age 21—copayment of $2.00 for each reimbursable visit. Dental services provided to recipients over age 21—copayment of $3.00 for each reimbursable visit.

MISSISSIPPI.—Prescription drugs—copayment of $.50 per prescription and refills.

MONTANA.—Prescription drugs—copayment of $.50 is required for each additional drug prescription after the first two prescriptions.

NEVADA.—Prescription drugs—copayment of $.50 for each prescription costing $10 or less; $1.00 for each prescription costing $10.01 through $25; $2.00 for each prescription costing $25.01 through $50; and $3.00 for each prescription costing $50.01 or more.

NEW MEXICO.—Prescription drugs—copayment of $.25 per prescription. Dental services—copayment of $2.00 per visit.

Table 4.—COST-SHARING FEATURES OF STATE MEDICAID PROGRAMS—Continued

NORTH CAROLINA.—Legend drugs and insulin—copayment of $.50 per prescription; optical supplies and services—copayment of $2.00 per visit; chiropractic services—copayment of $.50 per visit; dental services—copayment of $3.00 per visit; Mental Health Clinics—copayment of $1.00 per visit; Health Department Clinics—copayment of $1.00 per visit; optometrists's services—copayment of $1.00 per visit; Medically needy recipients: inpatient hospital services—copayment of $2.00 per inpatient day; outpatient hospital services—copayment of $2.00 per outpatient visit; physician's services—copayment of $1.00 per visit.

SOUTH CAROLINA.—Prescription drugs—copayment of $.50 on each prescription and refills.

SOUTH DAKOTA.—Prescription drugs—copayment of $.50 on each prescription.

VIRGINIA.—Prescription drugs—copayment of $.50 per prescription and refills dispensed on outpatient basis; eyeglasses—copayment of $2.00 for each pair and a $.50 copayment is imposed on the repair or replacement of parts of eyeglasses.

SOURCE: MEDICAID BUREAU, APRIL 1979.

E. RECENT STATE CHANGES IN PROGRAM COVERAGE

States can alter their Medicaid program at any time with Federal approval as long as the program remains within the Federal guidelines. Such alterations can be made to reflect shifting policy considerations, such as the desire to gradually expand or gradually limit the State program, or can be made as a result of temporary budgetary problems within the State.

Table 5 provides information on recent changes in Medicaid benefits.

Table 5.—CHANGES IN COVERAGE, JANUARY 1, 1978-JUNE 30, 1978

	Effective Date
ALABAMA:	
Increases:	
Added SNF coverage for individuals 65 or older in institutions for mental diseases.	3/1/78
Added ICF coverage for individuals 65 or older in institutions for mental diseases.	3/1/78
ARKANSAS:	
Increases:	
Added coverage of eyeglasses for adults.	10/1/77 [1]
Added coverage of optometrists' services for adults.	10/1/77 [1]
Increased prescribed drugs from 3 to 4 prescriptions filled per month to each recipient.	2/1/78
DISTRICT OF COLUMBIA:	
Increases:	
Increased the reimbursement fee for the following providers:	4/1/78

Provider	*Old Rate*	*New Rate*
Dentists	63.7% of the prevailing rate	75% of the prevailing rate
Optometrists	$12.00 for refractions	$16.00 for refractions

[1] These changes were initially reported for the prior period but withheld pending clearance by the Division of Policy and Standards.

Table 5.—CHANGES IN COVERAGE, JANUARY 1, 1978-JUNE 30, 1978—Continued

DISTRICT OF COLUMBIA—Continued

Increases—Continued

Provider	*Old Rate*	*New Rate*
Podiatrists	$4.80 for office visit/no surgery	$7.00 for office visit/additional for surgical procedure
Physicians	$4.80-$9.60 routine visit	$13.00-$20.00—routine visit $14.40-$40.00—new patients $22.80-$32.00—comprehensive history, diagnosis & physical examination
Anesthetists	$3.40 per unit	$6.00 per unit
Pharmacists	$1.80 non-institutional $1.80 institutional	$2.59 $2.00
Opticians	$5.00 plastic frames $7.00 combination plastic and metal	$7.00 $9.00

	Effective date
FLORIDA:	
Increases:	
Increased the net income levels for individuals in medical institutions and intermediate care facilities from $464.00 to $485.00.	7/1/77 [2]
Reductions:	
Instituted a $.50 copayment on all prescription drugs (new or refill).	11/1/77 thru 1/31/78 and 4/1/78 thru 4/12/78
GEORGIA:	
Reductions:	
Reduced home health visits to 100 per calendar year.	2/1/77 [1]
KANSAS:	
Reductions:	
Limited physician office visits to three per month.	10/1/77 [2]
Limited physician visit to a nursing home to one per month.	
MAINE:	
Increases:	
Added ICF coverage to the medically needy.	4/6/78
Added ICF/MR coverage to the medically needy.	4/6/78
MARYLAND:	
Increases:	
Increased the maximum fee paid for certain obstetrical procedures.	2/1/78

clearance by the Division of Policy and Standards.

[1] Change was approved 2/9/78 with a retroactive effective date of 2/1/77.

[2] This change was initially reported for the prior period but withheld pending clearance by the Division of Policy and Standards.

Table 5.—CHANGES IN COVERAGE, JANUARY 1, 1978-JUNE 30, 1978—Continued

	Effective date
MARYLAND—Continued	
Increases—Continued	
Increased ICF fee from $26.60 to $27.95 based on condition that nursing staff is upgraded.	1/1/78
Increased the fee for eyeglass frames from $4.50 to $7.50.	3/1/78
MICHIGAN:	
Increases:	
Removed prior approval requirement for optometrist services and changed frequency of eye examination limitation from one every 3 years to one every 2 years.	8/1/77 [2]
Removed the time restrictions on eyeglasses by allowing one pair of lenses and/or frames when medically necessary.	1/1/78
Pharmacy Reimbursement—Pharmacy payment methodology was revised to provide for payment based on the use of State developed MAC (maximum allowable cost) limits on multiple source generic drugs.	1/1/78
Hospital Reimbursement—Changed five indices in the hospital reimbursement formulae and added one appealable item.	1/1/78
NEBRASKA:	4/1/78
Increases:	
Added coverage for individuals under 21 in psychiatric hospitals.	
NEW HAMPSHIRE:	
Increases:	
The individual gross income level has been increased from $503.40 to $533.40 for aged, blind and disabled recipients living independently and in foster care, family care or group care settings.	1/1/78
The individual gross income level has been increased from $503.40 to $533.40 for aged, blind and disabled recipients in a medical facility or ICF who are receiving an SSI payment and who also meet the State's more restrictive standards.	1/1/78
The individual gross income level has been increased from $503.40 to $553.40 for aged, blind and disabled recipients in medical facility or ICF who would not receive a supplemental payment if they were outside the facility.	1/1/78
NEW JERSEY:	
Increases:	
Added coverage of unborn children in AFDC (aid to families with dependent children).	5/1/78
NEW MEXICO:	
Reductions:	
Instituted a $2.00 copayment for each dental services visit. (Excludes EPSDT and dental services performed as an inpatient hospital service.)	5/1/78

[2] This change was initially reported for the prior period but withheld pending clearance by the Division of Policy and Standards.

Table 5.—CHANGES IN COVERAGE, JANUARY 1, 1978-JUNE 30, 1978—Continued

	Effective date
NORTH CAROLINA:	
Increases:	
The net income level increased $22 per month for the blind in domiciliary facilities.	12/1/77 [1]
NORTH DAKOTA:	
Increases:	
Added coverage of all financially eligible persons under age 21 not otherwise eligible under the plan.	1/1/78
Reductions:	
Eliminated cosmetic type corrections under dental services.	1/1/78
Eliminated personal care services.	1/1/78
Eliminated prescribed diet remedies, as defined by the Medical Services Unit of the Social Service Board, and alcoholic beverage (spirits fermenti) from prescribed drugs.	1/1/78
PENNSYLVANIA:	
Increases:	
Removed payment restriction for orthopedic shoes.	5/15/78
TENNESSEE:	
Reductions:	
Eliminated optometrist services.	4/1/78
Eliminated denture services.	4/1/78
Eliminated services for individuals with speech, hearing, and language disorders.	4/1/78

F. MEDICAID REIMBURSEMENT PRACTICES

States are required by law to reimburse for inpatient hospital services on the basis of reasonable cost following the reimbursement practices of Medicare, unless they have approval from the Secretary of HEW to use an alternate method of reimbursement. The Secretary will approve an alternate system which varies from the Medicare method only if satisfied that (1) reasonable cost is paid (although the State in this case may develop the methods and standards for determining what reasonable cost is), and (2) the reasonable cost does not exceed the amount which would be determined as reasonable by Medicare. As of January 1978, ten States had received approval from HEW to use a reasonable cost reimbursement system for inpatient hospital services which was different from the system used by Medicare.

For all other services, including physician services, outpatient hospital services, and skilled nursing facility services, States are not required to use the Medicare method of payment. With the exception of skilled nursing facility services and intermediate care facility services, in fact, the only requirement is that the State Medicaid reimbursement may not exceed the amounts paid under Medicare. While there is an effective ceiling on payment, there is no corresponding floor. In the case of long term care institutional services (skilled nursing facility services and intermediate care facility services), a State is subject to the additional requirement that its payment system must be reasonably related to cost. This means that States are not required to use the Medicare reasonable cost system (although they may use it if they wish), but they must relate their reimbursement to the cost of care in some reasonable way, whether determined prospectively or retrospectively. Use of a cost-related payment system for long term care institutional services has been required by law since July 1, 1976. HEW has required States to have their systems fully operational by January 1, 1978.

Since August 1976, the Department has also established requirements by regulation for determining payments for prescription drugs: this system is referred to as MAC (Maximum Allowable Cost.) The purpose of the Maximum Allowable Cost regulations is to place an upper limit on payments made under Medicaid for selected multiple-source prescribed drugs (except where the physician specifies in writing that a higher cost drug is required). Payment for all drugs prescribed under Medicaid must be made on the basis of MAC or acquisition cost as estimated by the State (EAC) plus a dispensing fee, or the provider's usual and customary charge to the public, whichever is lower.

Table 6 provides information on the payment systems used by the States in their Medicaid programs for inpatient hospital services, outpatient hospital services, and physicians' services.

TABLE 6.—STATE MEDICAID METHODS OF REIMBURSEMENT FOR SERVICES

INPATIENT HOSPITAL SERVICES

All States use Title XVIII standards for determination of payments, except the following which have approval for alternative plans: California, Colorado, Illinois, Maryland, Michigan, New York, Pennsylvania, Massachusetts, Rhode Island, and Wisconsin.

OUTPATIENT HOSPITAL SERVICES

State	Same as Title XVIII	Other	Comment
Alabama	X		
Alaska	X		
Arkansas		X	Reasonable cost not to exceed Title XVIII payments for similar services.
California		X	Maximum allowable fee schedule.
Colorado		X	Reimbursed on an interim basis, based on billings; retrospective adjustment is made based on periodic cost audit.
Connecticut		X	Fee per visit or service.
Delaware		X	Usual and customary fee for type of service.
District of Columbia		X	Fixed fee basis.
Florida		X	Customary and prevailing charges which are reasonable, or per diem rate established by State agency based on cost report.
Georgia	X		
Guam		X	1970 Hawaii Relative Value Scale conversion factor of 7.0.
Hawaii		X	Lesser of reasonable cost or customary charges.
Idaho		X	Maximum allowable fees not exceeding reasonable charges.
Illinois		X	Reasonable cost determined by State agency.
Indiana		X	Usual and customary charges with fixed maximum rate.
Iowa	X		
Kansas	X		
Kentucky	X		
Louisiana		X	On cost or charges, whichever is lower.
Maine	X		
Maryland		X	Reasonable cost.
Massachusetts		X	Percentage of charges or fee per visit.
Michigan		X	Reasonable cost.
Minnesota		X	Customary charges.
Mississippi		X	75 percent of usual and customary charges not to exceed Title XVIII cost.
Missouri		X	Reasonable charge determined by the Division of Family Service.
Montana		X	Customary and reasonable charges not to exceed Title XVIII charges.
Nebraska	X		
Nevada		X	Lower of billed charge, or fixed fee per unit.
New Hampshire	X		
New Jersey		X	Reasonable covered charges.
New Mexico		X	Customary and reasonable charges not exceeding Title XVIII payments.
New York		X	Reasonable cost.
North Carolina		X	90 percent of allowable cost.
North Dakota		X	Rate in accordance with Blue Cross/Blue Shield rates.
Ohio		X	Customary and reasonable charges.
Oklahoma		X	Negotiated rates.
Oregon	X		
Pennsylvania		X	Fee schedule.
Puerto Rico		X	Reasonable cost.
Rhode Island		X	Fee schedule.
South Carolina		X	Reasonable cost.
South Dakota	X		
Tennessee	X		
Texas	X		
Utah		X	Customary charges which are reasonable with maximum fee schedule.
Vermont	X		
Virgin Islands		X	Fee schedule.
Virginia	X		
Washington		X	Fee schedule.
West Virginia		X	Fee schedule.
Wisconsin	X		
Wyoming		X	Customary and reasonable charges not exceeding Title XVIII payments.

TABLE 6—(Continued)

PHYSICIAN SERVICES

State	Same as Title XVIII	Other	Comment
Alabama	X		
Alaska		X	Usual, customary, and reasonable charges up to maximum established by department.
Arkansas	X		
California		X	Maximum allowable fee schedule.
Colorado		X	Reasonable charges according to unit values.
Connecticut		X	Customary and reasonable charges.
Delaware		X	Usual and customary fees.
District of Columbia	X		
Florida	X		
Georgia		X	Reasonable charges.
Guam		X	1970 Hawaii Relative Value Scale conversion factor of 7.0.
Hawaii		X	Usual and customary fees but not exceeding the 75th percentile of the range of customary charges prevailing in the State.
Idaho	X		
Illinois		X	Customary and reasonable charges not to exceed upper limits.
Indiana	X		
Iowa	X		
Kansas		X	Usual and customary charge with fixed maximum.
Kentucky		X	Usual, customary, reasonable and prevailing charges.
Louisiana	X		
Maine	X		
Maryland		X	Fixed fee schedules.
Massachusetts		X	Fixed negotiated fee schedule.
Michigan		X	Reasonable charges determined by Department of Social Services.
Minnesota		X	Usual and customary charges.
Mississippi		X	Fixed fee.
Missouri		X	Reasonable charge determined by the Missouri Division of Welfare.
Montana		X	Median charge by an individual practitioner for a given service.
Nebraska		X	Maximum payments set by Department of Public Welfare.
Nevada		X	Lower of billed charge, or fixed fee per unit.
New Hampshire		X	Fee schedule.
New Jersey		X	Not to exceed the 75th percentile of the range of customary charges.
New Mexico	X		
New York		X	Fee schedules.
North Carolina		X	Usual, customary, and reasonable charges subject to limitations.
North Dakota		X	Lowest of actual charge, median charge or reasonable charge.
Ohio		X	Customary and reasonable charges up to maximum limit.
Oklahoma	X		
Oregon		X	Fee schedules.
Pennsylvania		X	Customary charges with maximum limit.
Puerto Rico		X	Actual cost.
Rhode Island		X	Reasonable charges up to maximum under Title XVIII.
South Carolina		X	Reasonable charges not exceeding upper limits.
South Dakota	X		
Tennessee		X	Not to exceed 90 percent of the 75th percentile of prevailing customary charges.
Texas		X	Reasonable and customary charge.
Utah		X	80 percent of usual, customary, and reasonable fee not exceeding 1974 Title XVIII profile.
Vermont	X		
Virgin Islands		X	Reasonable charges.
Virginia		X	Usual, customary, and reasonable charges.
Washington		X	Usual, customary, and reasonable charge up to maximum.
West Virginia		X	Fee schedule.
Wisconsin		X	Lowest of actual charge, median of physician's charge for service, reasonable charge, or physician's Dec. 23, 1974 rate for service.
Wyoming	X		

Source: Medicaid Bureau March, 1979.

G. BASIC MEDICAID ELIGIBILITY COVERAGE, BY STATE

Medicaid eligibility is linked to the Federally assisted welfare programs of Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) for the aged, blind, and disabled. In general, States must cover all cash assistance recipients, with the exception that States have the option of limiting Medicaid coverage of SSI recipients by requiring that such recipents meet any more restrictive eligibility standard which was in effect in the State on January 1, 1972, prior to the implementation of the SSI program. States exercising this option are required to provide for a "spend-down" for all aged, blind, and disabled persons (not just SSI cash recipients), by deducting any medical expenses incurred from income in determining Medicaid eligibility.

Columns 2 and 3 of Table 7 show the States which have chosen to cover all SSI recipients and those who have chosen to limit coverage by reverting to some aspect of their more restrictive standard in effect prior to implementation of SSI.

States may pay a cash supplement to the basic SSI payment. Some persons who have enough income so that they are not eligible for a Federal payment nonetheless receive a State supplement. States may provide Medicaid to persons whose only welfare payment is a State supplement at their option. Columns 4, 5, 6, and 7 indicate the extent of this State Medicaid coverage.

In addition to covering cash assistance recipients. States can provide Medicaid coverage to the "medically needy," those who would be eligible for cash assistance (i.e., they fall within one of the categorical groups of aged, blind, disabled, or a member of a family with dependent children) except for the level of their income. Column 8 of Table 7 shows the 33 States currently providing coverage of the medically needy.

H. OPTIONAL MEDICAID COVERAGE GROUPS

States can also provide Medicaid coverage to certain special groups within the State. One such group consists of any financially eligible children under 21 years of age regardless of whether they are members of intact families or not. This is the only situation under Medicaid where the requirement of fitting into one of the welfare categories is overridden. Only 20 States have provided this coverage. Column 3 of Table 8 indicates which States do this.

Another special coverage group is members of families with unemployed fathers who are not receiving unemployment compensation. (Persons receiving unemployment compensation are precluded from coverage, although a recent court decision provided that persons had

the right to refuse unemployment compensation and receive welfare benefits instead, if they are otherwise eligible.) Generally, States provide Medicaid to such persons only when they include families of unemployed fathers in their AFDC program. Further, simply being unemployed is not enough to qualify for coverage. As with the other eligible groups, income and resources tests used for the welfare program (or for the medically needy) are applied. Columns 1 and 2 of Table 8 indicate State coverage of unemployed fathers and their families.

TABLE 7.—BASIC MEDICAID ELIGIBILITY COVERAGE BY STATE, JANUARY, 1979

State	AFDC	All SSI recipients	More restricted standard	State Supplement Recipients			Medically needy
				Aged	Blind	Disabled	
Alabama	X	X		X	X	X	
Alaska	X	X		X	X	X	
Arizona [1]							
Arkansas	X	X					X
California	X	X					X
Colorado	X	X		X	X	X	
Connecticut	X		X	X	X	X	X
Delaware	X	X		X	X	X	
District of Columbia	X	X					X
Florida	X	X		X	X	X	
Georgia	X	X					
Guam	X			[2]			X
Hawaii	X		X	X	X	X	X
Idaho	X	X		X	X	X	
Illinois	X		X	X	X	X	X
Indiana	X		X				
Iowa	X	X		X	X	X	
Kansas	X	X		X	X	X	X
Kentucky	X	X		X	X	X	X
Louisiana	X	X					X
Maine	X	X		X	X	X	X
Maryland	X	X		X			X
Massachusetts	X	X		X	X	X	X
Michigan	X	X		X	X	X	X
Minnesota	X		X				X
Mississippi	X		X				
Missouri	X		X				
Montana	X	X					X
Nebraska	X		X	X	X	X	X
Nevada	X	X		X	X	X	
New Hampshire	X		X	X	X	X	X
New Jersey	X	X					
New Mexico	X	X					
New York	X	X					X
North Carolina	X		X	X	X	X	X
North Dakota	X	X					X
Ohio	X		X	X		X	
Oklahoma	X		X	X	X	X	X
Oregon	X	X		X	X	X	
Pennsylvania	X	X					X
Puerto Rico	X			[2]			X
Rhode Island	X	X		X	X	X	X
South Carolina	X	X		X	X	X	
South Dakota	X	X		X	X	X	
Tennessee	X	X					X
Texas	X	X					
Utah	X		X				X
Vermont	X	X		X	X	X	X
Virgin Islands	X			[2]			X
Virginia	X		X	X	X	X	X
Washington	X	X		X	X	X	X
West Virginia	X	X		X		X	X
Wisconsin	X	X					X
Wyoming	X	X					
Total	53	35	15	30	27	29	33

[1] No Medicaid program.

[2] The SSI program does not provide coverage in Guam, Puerto Rico, or the Virgin Islands. Federal-State matching programs for assistance to the aged, blind and disabled remains in effect, and Medicaid is provided for these persons.

Source: DHEW/HCFA

TABLE 8.—OPTIONAL MEDICAID COVERAGE GROUPS, JANUARY, 1979

State	Unemployed fathers and their families	Children of unemployed fathers	All financially eligible individuals under age 21
Alabama			
Alaska			
Arizona [1]			
Arkansas			X
California	X	X	X
Colorado	X	X	
Connecticut	X	X	X
Delaware	X	X	
District of Columbia	X	X	X
Florida			
Georgia			
Guam	X	X	
Hawaii	X	X	X
Idaho			
Illinois	X	X	
Indiana			
Iowa	X	X	
Kansas	X	X	
Kentucky	X	X	
Louisiana			
Maine			X
Maryland	X	X	X
Massachusetts	X	X	X
Michigan		X	X
Minnesota	X	X	X
Mississippi			
Missouri	X	X	
Montana	X	X	
Nebraska	X	X	
Nevada			
New Hampshire			
New Jersey	X	X	X
New Mexico			
New York	X	X	X
North Carolina			
North Dakota			
Ohio	X	X	
Oklahoma			X
Oregon	X	X	
Pennsylvania	X	X	X
Puerto Rico	X	X	X
Rhode Island	X	X	
South Carolina			
South Dakota			
Tennessee			
Texas			
Utah	X	X	X
Vermont	X	X	X
Virgin Islands	X	X	X
Virginia			
Washington	X	X	X
West Virginia	X	X	
Wisconsin	X	X	X
Wyoming			
Total	30	31	20

[1] No Medicaid program.

II. Medicaid Trend Data, 1966-1979

The second section of this report (Tables 9-19) provides basic trend data on expenditures and recipients under the Medicaid program since its inception in 1966.

A. TOTAL MEDICAID PROGRAM PAYMENTS TO PROVIDERS OF HEALTH CARE

Table 9 shows the dramatic growth in total Medicaid expenditures since enactment of the program. The column titled "Kerr-Mills and related programs" refers to the medical vendor payment programs in effect prior to Medicaid, most notably the Kerr-Mills program, or Medical Assistance for the Aged (MAA). This program, enacted in 1960, provided for Federal matching for State programs of medical vendor payments made on behalf of aged cash assistance recipients and the aged medically needy.

The increased dollar totals are graphically presented in Table 10, while Table 11 shows the percent increase in Medicaid payments.

TABLE 9.—TOTAL (FEDERAL AND STATE) MEDICAID (AND RELATED) PROGRAM PAYMENTS TO PROVIDERS OF HEALTH CARE, FISCAL YEARS 1966-1979

(Amounts in thousands)

Fiscal Year	Medicaid	Kerr-Mills and related programs	Total	Percent increase over previous year
1966	$362,578	$1,229,042	$1,591,620	.....
1967	1,936,753	334,243	2,270,996	+42.7
1968	3,221,707	229,669	3,451,376	+52.0
1969	[1] 4,126,380	225,106	4,351,486	+26.1
1970	[1] 4,977,585	116,315	5,093,901	+17.1
1971	[1] 6,345,199	.....	6,345,199	+24.6
1972	[1] 7,346,131	.....	7,346,131	+15.8
1973	8,713,761	.....	8,713,761	+18.6
1974	9,737,398	.....	9,737,398	+11.7
1975	12,086,166	.....	12,086,166	+24.1
1976	13,977,348	.....	13,977,348	+15.6
1977 [3]	[2] 16,257,024	.....	[2] 16,257,024	+16.3
1978	[2] 18,965,000	.....	[2] 18,965,000	+16.6
1979	[2] 19,662,000	.....	[2] 19,662,000	+ 3.6
1980	[2] 21,022,000	.....	[2] 21,022,000	+ 6.9

[1] Payments to intermediate care facilities are included in the total for Fiscal Years 1969-1972 even though they were administered under the cash programs until January 1, 1972, when they were switched to Title XIX.

[2] Estimated figures from the President's budget.

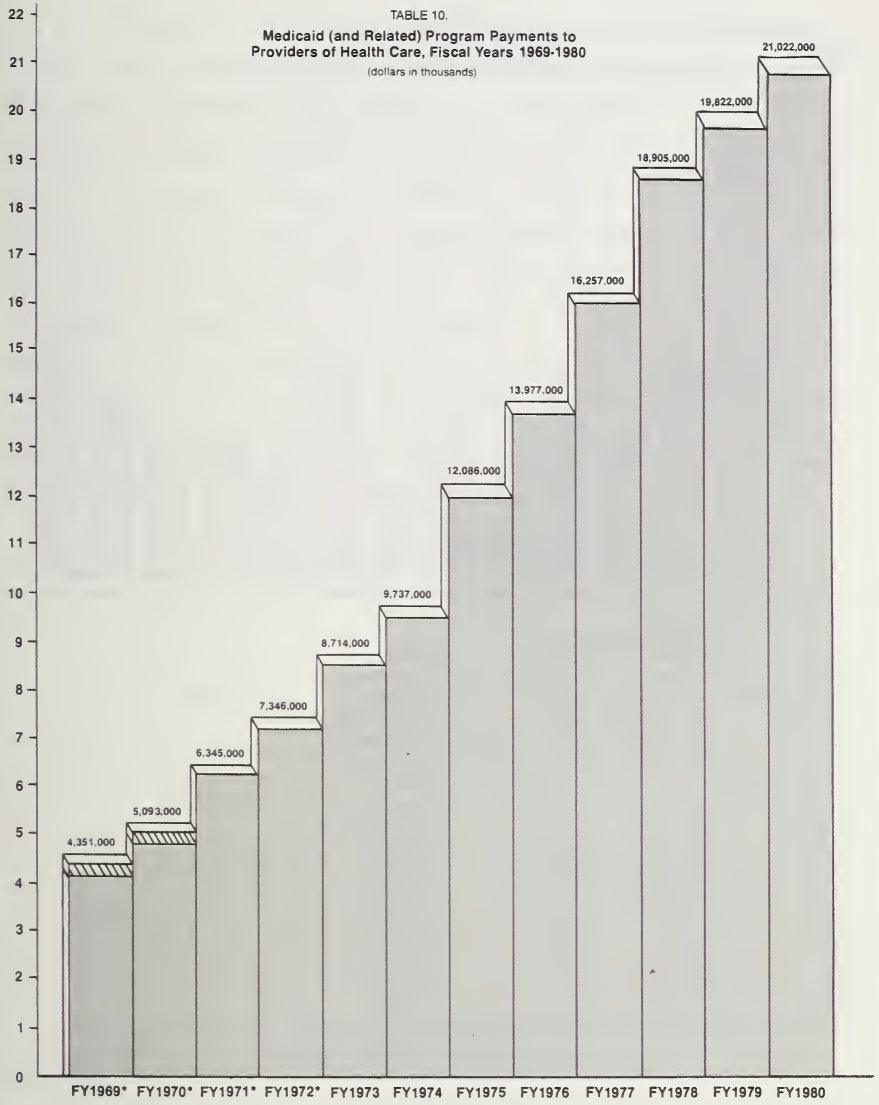
[3] Fiscal Year changed from July-June in 1976 to October-September in 1977.

Source: State expenditure data, except for Fiscal Years 1977-1979 which are based on budget estimates of States' expenditures.

TABLE 10.

Medicaid (and Related) Program Payments to Providers of Health Care, Fiscal Years 1969-1980

(dollars in thousands)



*NOTE: Intermediate care facility payments are included in the totals for FY 1969-72 even though they were administered under the cash assistance program until January 1, 1972, when they were switched to Title XIX.

Source:

Actual State expenditure data except for FY 77-79 which are based on budget estimates of States' expenditures.

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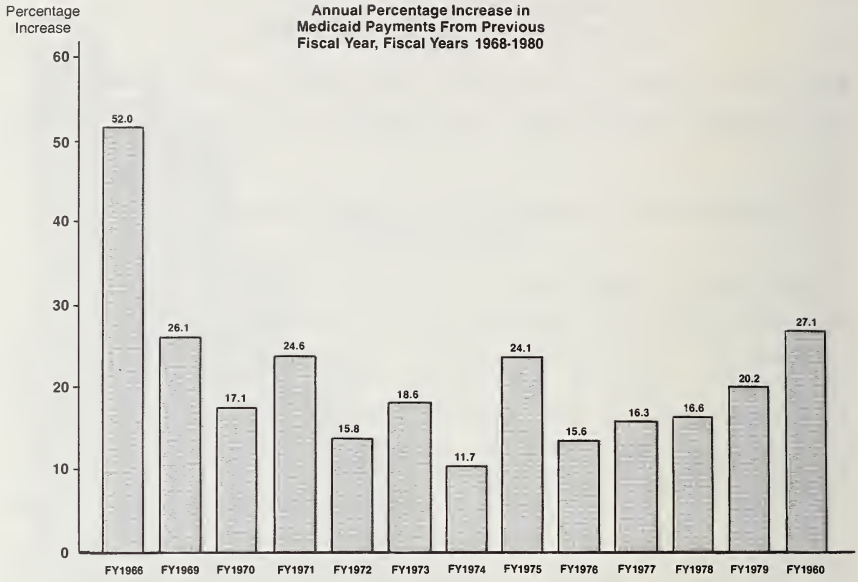
LEGEND
MEDICAID*
OTHER
X,XXX,XXX TOTAL

TABLE 11.

Annual Percentage Increase in Medicaid Payments From Previous Fiscal Year, Fiscal Years 1968-1980



Source: Actual State expenditure data, except for FY 1977-1979 which are based on budget estimates of States' expenditures.

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B. NUMBER OF MEDICAID AND CASH ASSISTANCE RECIPIENTS

The number of Medicaid recipients has also increased greatly in the years since enactment of the program, as demonstrated in Table 12.

This growth in the number of Medicaid recipients is related to the growth in the cash assistance population during the same time period, due to the general linkage of Medicaid eligibility to the cash programs. Table 12 compares the average monthly number of cash assistance recipients during each year since 1969 with the total yearly number of Medicaid recipients in those years. While the figures are not completely comparable (cash recipients are expressed as the average monthly number of recipients during the year, while the Medicaid recipients are expressed as the total number of different individuals receiving services at some time during the year), the relationship between the increasing cash assistance population and increasing number of Medicaid recipients is obvious from the table.

TABLE 12.—NUMBER OF MEDICAID AND CASH ASSISTANCE RECIPIENTS, AND PERCENT INCREASES, FISCAL YEARS 1969-1979

Fiscal Year	Annual number of Medicaid recipients [1] (in thousands)	Percent increase over previous year	Average monthly number of cash assistance recipients (in thousands)	Percent increase over previous year
1969	12,060	.....	8,966	.....
1970	14,507	+20.3	10,373	+15.7
1971	[2] 17,965	+23.8	12,650	+22.0
1972	17,990	+0.1	13,809	+9.2
1973	18,818	+4.6	14,230	+3.1
1974	20,842	+10.7	14,246	+0.1
1975	21,197	+1.7	15,097	+6.0
1976	[3] 21,606	+1.9	15,647	+3.6
1977 [4]	[3] 21,585	−0.1	15,434	−1.4
1978	[3] 21,348	−1.1	15,368	−1.0
1979	[3] 21,378	+0.1	15,528	+1.4

[1] Does not include recipients of medical assistance under Kerr-Mills.
[2] Includes some recipients of aid under nonfederally matched programs.
[3] Estimated.
[4] Fiscal Year changed from July-June in 1976 to October-September in 1977.
Source: HCFA/DHEW.

C. MEDICAID RECIPIENTS BY BASIS OF ELIGIBILITY

Medicaid eligibility is linked to the Federally assisted cash assistance programs. Medicaid recipients must qualify on the basis of relatedness to one of the following eligibility categories: aged; blind; disabled; children under age 21; and adults in AFDC families.

The increase in the number of Medicaid recipients has varied at different points in time by eligibility category. Tables 13 and 14 detail the growth in the number of recipients by category of eligibility from FY 1970 through FY 1979.

TABLE 13.—NUMBER OF MEDICAID RECIPIENTS [1] BY BASIS OF ELIGIB ILITY, AND PERCENTAGE CHANGE OVER PREVIOUS YEAR, FISCAL YEARS 1970-1979

(Recipients in Thousands)

Basis of Eligibility	1970		1971 [2]		1972		1973		1974		1975		1976		1977		1978		1979	
	Number of recipients	Percent change over prior year	Number of recipients	Percent change over prior year	Number of recipients	Percent change over prior year	Number of recipients	Percent change over prior year	Number of recipients	Percent change over prior year	Number of recipients	Percent change over prior year	Number of recipients	Percent change over prior year	Number of recipients	Percent change over prior year	Number of recipients	Percent change over prior year	Number of recipients	Percent change over prior year
Total	14,507	+20.3	17,965	+23.8	17,990	+ 0.1	18,818	+ 4.6	20,842	+10.8	21,197	+ 1.7	21,606	+ 1.9	21,585	— 0.1	21,348	—1.1	21,378	+0.1
Aged	3,200	+10.3	4,076	+27.4	3,690	— 9.5	3,549	— 3.8	3,805	+ 7.2	3,699	— 2.8	3,828	+ 3.5	3,664	— 4.3	3,567	—2.7	3,470	+2.7
Blind	107	+42.7	135	+26.2	117	—13.3	102	—12.8	136	+33.3	107	—21.3	113	+ 5.6	127	+12.4	131	+3.2	136	+3.8
Disabled	1,200	+25.0	1,770	+47.5	1,799	+ 1.6	1,843	+ 2.5	2,280	+23.7	2,308	+ 1.2	2,665	+15.5	2,994	+12.4	3,099	+3.5	3,210	+3.6
Children under Age 21	6,500	+10.2	8,161	+25.6	8,722	+ 6.9	9,178	+ 5.2	10,110	+10.2	10,421	+ 3.1	10,134	— 2.8	9,999	— 1.3	9,831	—1.7	9,838	+0.1
Adults in families with dependent children	3,500	+55.1	3,823	+ 9.2	3,662	— 4.2	4,145	+13.2	4,511	+ 8.8	4,662	+ 4.4	4,866	+ 3.4	4,801	— 1.3	4,720	—1.7	4,724	+0.1

[1] Recipients are people who had at least some of their health bills paid by Medicaid.

[2] Includes some recipients of aid under nonfederally matched medical assistance programs.

Source: Published data by the Office of Policy Planning and Research; recipients for Fiscal Years 1976-1979, were estimated on the basis of OPPR data for previous Fiscal Years, projected with the aid of data on the average monthly number of recipients and the trend in annual counts of recipients.

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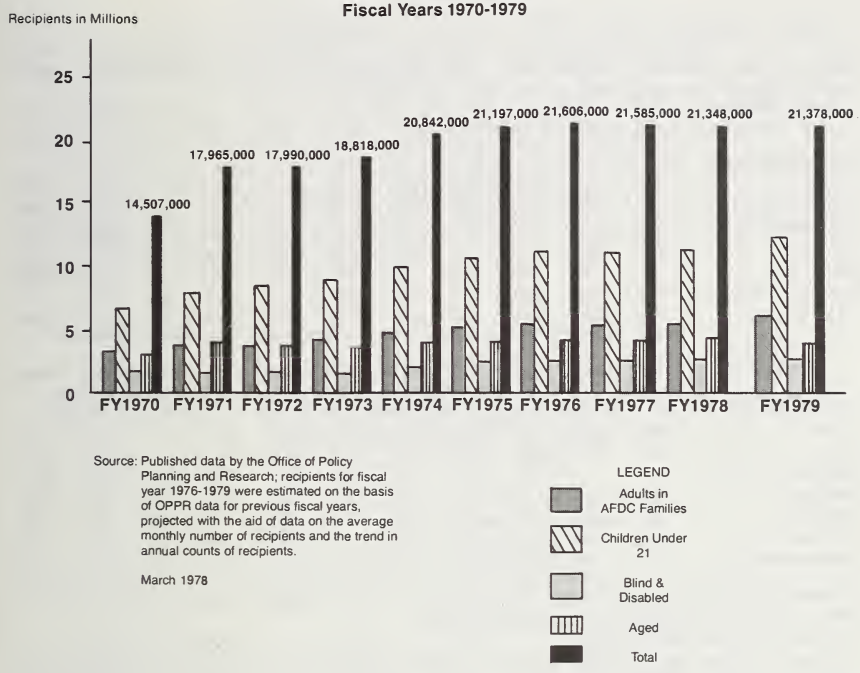
Table 14.

Number of Medicaid Recipients.
Fiscal Years 1970-1979



Source: Published data by the Office of Policy Planning and Research; recipients for fiscal year 1976-1979 were estimated on the basis of OPPR data for previous fiscal years, projected with the aid of data on the average monthly number of recipients and the trend in annual counts of recipients.

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D. MEDICAID BENEFIT EXPENDITURES BY TYPE OF SERVICE

Medicaid expenditures are made for a number of different medical services. Table 15 details total program expenditures for each of the major types of service from FY 1967 through FY 1977. It is evident that the great proportion of expenditures are made for the institutional services (inpatient hospital, skilled nursing home, and intermediate care facilities), with such services accountng for 73.9 percent of program expenditures in FY 1967 and 70.7 percent in FY 1977. Although the share accounted for by institutional services as a whole has remained fairly constant, there have been some noticeable shifts within institutional services. There has been a decline in both inpatient hospital (from 40.2 percent to 31.5 percent) and skilled nursing facility care (from 33.7 percent to 17.2 percent), with an increase in expenditures for intermediate care services, partially due to an increasing number of States covering intermediate care facility services.

TABLE 15.—TOTAL (FEDERAL AND STATE) MEDICAID BENEFIT EXPENDITURES [1] BY TYPE OF SERVICE, FISCAL YEARS 1967-1977

Type of Service	Fiscal Year										
	1967	1968	1969	1970	1971	1972	1973	1974[2]	1975[2]	1976[2]	1977[2]
Total [3] amount (in millions)	2,271	3,451	4,368	5,112	6,476	7,713	8,810	10,149	12,318	14,245	16,300
Inpatient hospital care	913	1,361	1,586	1,887	2,288	2,944	3,113	3,399	3,915	4,518	5,128
Nursing home care	766	1,064	1,291	1,321	1,674	1,778	1,849	2,027	2,471	2,599	2,808
Intermediate care [4]	.....	.....	95	304	537	743	1,162	1,601	2,179	2,781	3,584
Physicians	225	380	516	578	717	804	955	1,086	1,236	1,387	1,503
Dental care	72	190	209	169	181	186	211	265	341	387	400
Prescribed drugs	179	235	301	395	473	549	612	707	816	960	1,018
Other Services [5]	115	221	369	457	605	710	907	1,063	1,360	1,615	1,858
Total (percentage distribution)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Inpatient hospital care	40.2	39.4	36.3	36.9	35.3	38.2	35.3	33.5	31.8	31.7	31.5
Nursing home care	33.7	30.8	29.6	25.8	25.8	23.1	21.0	20.0	20.1	18.2	17.2
Intermediate care [4]	.....	.....	2.2	5.9	8.3	9.6	13.2	15.8	17.7	19.5	22.0
Physicians	9.9	11.0	11.8	11.3	11.1	10.4	10.8	10.7	10.0	9.7	9.2
Dental care	3.2	5.5	4.8	3.3	2.8	2.4	2.4	2.6	2.8	2.7	2.5
Prescribed drugs	7.9	6.8	6.9	7.7	7.3	7.1	7.0	7.0	6.6	6.7	6.2
Other services [5]	5.1	6.4	8.4	8.9	9.3	9.2	10.3	10.5	11.0	11.3	11.4

[1] Expenditures from Federal, State, and local funds under Medicaid. Excludes per capita payments for part B of Medicare and administrative costs.

[2] Does not include data for Guam.

[3] Totals vary from those reported on Table 9. Table 9 is based on accounting data, which are not available in detail on types of service or basis of eligibility. The more detailed data used in this table are available only through the statistical reporting system, which reports totals which differ somewhat from the accounting totals. Note also that columns may not add due to rounding.

[4] Payments to intermediate care facilities are included in the totals for Fiscal Years 1969-72 even though they were administered under the cash assistance programs until January 1, 1972, when they were switched to Title XIX.

[5] Other services include laboratory and radiological services, home health, family planning services, outpatient hospital services, clinic services, and amounts for which types of services were not reported.

Source: Office of Policy Planning and Research, HCFA, DHEW.

E. MEDICAID SHARE OF PERSONAL HEALTH CARE EXPENDITURES FOR SPECIFIED SERVICES, FY 1977

Medicaid has assumed an increasing proportion of personal health care expenditures in the United States since enactment of the program. Medicaid's share of personal health care expenditures rose from approximately 5 percent in FY 1967 to more than 10.0 percent in FY 1977, and Medicaid's share of public expenditures for personal health care services increased from 18 percent to 23.8 percent in the same time period. Table 16 shows personal health care expenditures for specified services in FY 1977, and details Medicaid's share of those expenditures.

Especially noteworthy are the Medicaid expenditures for nursing home care, which comprise a major portion (50.6%) of the nation's

expenditures for long term care services. Even this statistic understates Medicaid's share of expenditures for skilled nursing care and intermediate care, for the definition of nursing home care used to compute total national health expenditures includes personal care homes providing some nursing care which would not be considered a medical service for purposes of Medicaid or Medicare program coverage. Medicaid's share of the Nation's total nursing home expenditures is graphically portrayed in Table 17.

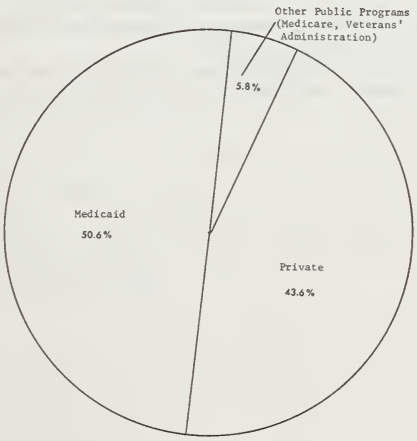
TABLE 16.—PERSONAL HEALTH CARE EXPENDITURES, AND MEDICAID'S SHARE OF EXPENDITURES, FOR SPECIFIED SERVICES, FISCAL YEAR 1977

(dollar amounts in millions)

Type of service	Personal health care expenditures				Medicaid as percent of total	Medicaid as percent of public
	Source of funds					
	Total [1]	Private [1]	Public			
			Total [1]	Medicaid [2]		
Total	162,627	94,185	68,442	16,257	10.0	23.8
Hospital care	65,627	29,427	36,199	5,964	11.0	16.5
Nursing home care	12,618	5,434	7,184	6,380	50.6	88.8
Physicians' services	32,184	24,360	7,824	1,827	5.67	23.4
Dentists' services	10,020	9,520	500	398	3.97	79.6
Drugs and drug sundries	12,516	11,373	1,143	1,015	8.10	88.8
All other	4,322	1,105	3,217	345	7.98	10.7

[1] Source: Social Security Administration, Research and Statistics Note No. 41, July 1978.
[2] Source: HCFA/DHEW.

Table 17.—MEDICAID'S SHARE OF NURSING HOME CARE EXPENDITURES, FISCAL YEAR 1977



F. MEDICAID PAYMENTS ADJUSTED FOR INCREASES IN RECIPIENTS, AND PRICES

Previous tables have separately examined the increases in Medicaid expenditures and Medicaid recipients. Table 18 combines the two, analyzes the relative change in expenditures per recipient from FY 1968 to FY 1978, and adjusts the expenditures per recipient for the increasing price of medical care during that time period. The final result, payments in constant dollars per recipient, provides a rough idea of increased program costs, net of the effects of increased recipients and increasing prices, and indicates that payments in constant dollars have remained virtually unchanged over the last few years.

The use of the Medical Care Price Index for this adjustment should be viewed with some caution, for on the one hand reimbursement levels under Medicaid are often slow to respond to general medical care prices, and on the other, the index of cost increases for hospital care has increased significantly faster than the Medical Care Price Index.

TABLE 18.—MEDICAID PAYMENTS ADJUSTED FOR INCREASES IN RECIPIENTS AND PRICES, FISCAL YEARS 1968-1979

Fiscal Year	Total (Federal and State) Medicaid payments (thousands)	Yearly number of Medicaid recipients (thousands)[1]	Medical care price index [2]	Percent growth of medical care costs	Annual payments per Medicaid recipient	Payment per recipient in constant dollars
1968 [3]	$3,451,376	11,500	100.0	6.1	$300	$300
1969 [3]	4,351,486	12,060	106.9	6.9	361	338
1970 [3]	5,093,901	14,507	113.7	6.4	351	309
1971	6,345,199	17,965	121.0	6.4	353	292
1972	7,346,131	17,990	124.9	3.2	408	327
1973	8,713,761	18,818	129.8	3.9	463	357
1974	9,737,398	20,842	141.9	9.3	467	329
1975	12,086,166	21,197	158.9	12.0	570	359
1976	13,977,348	21,606	174.1	9.0	647	372
1977 [4]	16,257,024	21,585	190.8	9.6	753	395
1978 [4]	18,965,000	21,348	206.4	9.6	888	430
1979 [4]	19,662,000	21,378	208.2	9.7	919	441

[1] Includes some recipients of aid under nonfederally matched programs.

[2] BLS Medical Care Price Index with adjustments to make 1968=100, estimated for year 1979.

[3] Includes payments under the Kerr-Mills program.

[4] Medicaid data for Fiscal Years 1977 and 1978 were estimated by MMB Budget Office.

Source: U.S. Bureau of Labor Statistics, and State expenditure data provided by HCFA/DHEW.

G. FEDERAL MEDICAL ASSISTANCE PERCENTAGES

The Federal share of State medical vendor payments is determined by a statutory formula designed to provide a higher percentage of Federal matching to States with low per capita incomes, and a lower percentage of Federal matching to States with higher per capita incomes. Under the formula, if a State's per capita income is equal to the national average per capita income, the Federal share would be 55 percent. If a State's per capita income exceeds the national average, the Federal share is lower, with a statutory minimum of 50 percent. If a State's per capita income is lower than the national average, the Federal share is increased, up to a maximum of 83 percent; however, no State currently receives more than 77.55 percent.

The actual formula used in determining the State and Federal share is as follows.

$$\text{State share} = \frac{(\text{State per capita income})^2}{(\text{National per capita income})^2} \times 45 \text{ percent}$$

Federal share = 100 percent minus the State share (with a minimum of 50 percent and a maximum of 83 percent)

The formula provides for squaring both the State and national average per capita incomes; this procedure magnifies any differences between the State's income and the national average. Consequently, Federal matching to lower income States is increased, and Federal matching to higher income States is decreased. However, the statutory minimum of 50 percent eliminates much of the impact on higher income States.

Table 19 shows the Federal Medicaid Assistance Percentages in effect since enactment. It should be noted, however, that family planning services are Federally matched at a 90 percent rate in all States.

These percentages apply to medical vendor payments only. Administrative costs are generally matched by a 50 percent Federal contribution, with the following exceptions: the Federal government will match 90 percent of the costs of developing automated claims processing and management information systems, and 75 percent of the costs of operating such systems; costs of skilled nursing facility inspectors are matched at a 100 percent rate; and costs of professional medical personnel used in program administration are matched at a 75 percent rate. Costs of State Medicaid fraud and abuse control units located organizationally outside of the single State agency are also matched at the 90 percent rate.

TABLE 19.—FEDERAL MEDICAL ASSISTANCE PERCENTAGES

State	Promulgated for the periods— Jan. 1, 1966— June 30, 1967	July 1, 1969— June 30, 1971	July 1, 1971— June 30, 1973	July 1, 1973— June 30, 1975	July 1, 1975— Sept. 30, 1977	Oct. 1, 1977— Sept. 30, 1979	Oct. 1, 1979— Sept. 30, 1981
Alabama	79.85	78.54	78.43	75.93	73.79	72.58	71.32
Alaska	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Arizona [1]	63.94	66.42	64.15	61.92	60.48	60.81	61.47
Arkansas	81.67	79.76	79.42	76.31	74.60	72.06	72.87
California	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Colorado	53.08	56.24	57.61	57.22	54.69	53.71	53.16
Connecticut	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Delaware	50.00	50.00	50.00	50.00	50.00	50.00	50.00
District of Columbia	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Florida	65.21	64.10	60.67	60.95	57.34	56.65	58.94
Georgia	74.91	71.48	69.67	66.96	66.10	65.82	66.76
Guam	55.00	50.00	50.00	50.00	50.00	50.00	50.00
Hawaii	52.97	50.75	50.83	50.00	50.00	50.00	50.00
Idaho	70.73	68.91	71.56	69.50	68.18	63.58	65.70
Illinois	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Indiana	55.77	52.85	55.05	57.01	57.47	57.86	57.28
Iowa	60.39	55.27	58.07	59.72	57.13	51.96	56.57
Kansas	61.45	57.78	59.06	55.37	54.02	52.35	53.52
Kentucky	76.70	74.30	73.49	72.12	71.37	69.71	68.07
Louisiana	76.41	73.57	73.49	72.80	72.41	70.45	68.82
Maine	69.57	68.33	69.43	70.03	70.60	69.74	69.53
Maryland	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Massachusetts	50.00	50.00	50.00	50.00	50.00	51.62	51.75
Michigan	50.31	50.00	50.00	50.00	50.00	50.00	50.00
Minnesota	60.46	56.95	56.82	57.37	56.84	55.26	55.64
Mississippi	83.00	83.00	83.00	80.55	78.28	78.09	77.55
Missouri	53.90	59.29	59.53	59.94	58.98	60.66	60.36
Montana	62.86	64.72	67.16	66.08	63.21	61.10	64.28
Nebraska	60.39	57.25	58.48	57.86	55.59	53.46	57.62
Nevada	50.00	50.00	50.00	50.00	50.00	50.00	50.00
New Hampshire	61.31	59.18	59.36	62.05	60.28	62.85	61.11
New Jersey	50.00	50.00	50.00	50.00	50.00	50.00	50.00
New Mexico	70.73	71.48	72.63	72.01	73.29	71.84	69.03
New York	50.00	50.00	50.00	50.00	50.00	50.00	50.00
North Carolina	75.58	73.96	72.84	70.01	68.03	67.81	67.64
North Dakota	66.67	70.48	71.28	70.12	57.59	50.71	61.44
Ohio	52.33	52.42	53.65	53.59	53.39	55.46	55.10
Oklahoma	70.32	68.84	69.02	68.07	67.42	65.42	63.64
Oregon	54.12	56.35	57.39	59.40	59.04	57.29	55.66
Pennsylvania	54.38	54.60	55.45	55.14	55.39	55.11	55.14
Puerto Rico	55.00	50.00	50.00	50.00	50.00	50.00	50.00
Rhode Island	56.13	51.70	50.26	55.37	56.55	57.00	57.81
South Carolina	81.30	78.68	78.00	75.00	73.58	71.93	70.97
South Dakota	71.05	69.91	69.69	70.25	67.23	63.80	68.78
Tennessee	76.86	74.62	74.35	72.28	70.43	68.88	69.43
Texas	67.27	65.66	65.18	63.53	63.59	60.66	58.35
Utah	66.30	68.23	69.88	69.95	70.04	68.98	68.07
Vermont	68.44	64.96	64.71	65.38	69.82	68.02	68.40
Virgin Islands	55.00	50.00	50.00	50.00	50.00	50.00	50.00
Virginia	66.96	65.04	64.03	61.58	58.34	57.01	56.54
Washington	50.81	50.00	50.00	53.13	53.72	51.64	50.00
West Virginia	74.27	75.73	76.97	73.52	71.90	70.16	67.35
Wisconsin	57.60	55.21	56.28	60.02	59.91	58.53	57.95
Wyoming	55.47	60.38	62.73	60.99	60.94	53.44	50.00

[1] Not applicable; no Title XIX program in effect.
Source: MMB/HCFA/HEW.

III. Current Medicaid Data

The third section of the report (Tables 20-64) provides information on a State-by-State basis on current Medicaid programs—including their relative size and scope, expenditure patterns, average payments and eligibility levels.

A. MEDICAID EXPENDITURES COMPUTABLE FOR FEDERAL FUNDING, BY STATE

Table 20 details total Medicaid expenditures computable for Federal funding in each State, and shows the Federal and the State share of those expenditures.

Federal matching funds under Title XIX are available only for services included in the State plan that are within the scope of services covered by the Federal law and, more importantly, only for persons who fall within the categories of persons eligible for benefits (the aged, blind, disabled, children under 21, and adults in families with dependent children where one parent is absent, unemployed or incapacitated.) Only State (or State and local) expenditures for covered services for eligible persons may be used to claim Federal matching funds.

B. TOTAL FEDERAL, STATE, AND LOCAL MEDICAID EXPENDITURES, BY STATE

In actual operation of medical assistance programs, some States and localities also provide medical services to persons who are not covered under the terms of the Federal law; these expenditures may not be used to receive Federal matching funds. They may account, however, for a significant demand on the resources of county and local governments. Table 21 provides information on these expenditures. In this table, total expenditures for medical assistance, including expenditures for persons on general assistance programs and others who are not eligible for Medicaid under the Federal law, are shown; that is, both expenditures that are computable for Federal matching and those that are not. The Federal share of medical assistance funds is the same as in Table 20, since this represents the Federal share of the funds expended that are computable for Federal matching. In a number of instances, however, the total of the State and local expenditures exceeds the amounts shown in Table 20. It should be noted that when State Medicaid plans are reduced, whether

TABLE 20.—STATE-BY-STATE MEDICAID EXPENDITURES, FISCAL YEAR 1977
(in millions of dollars)

State	Total Medicaid Payments [1]	Federal Share [2]	State/Local Share [2]
Alabama	196.2	144.0	52.2
Alaska	19.1	10.5	8.6
Arizona [3]	---	---	---
Arkansas	146.1	110.1	36.0
California	2,214.4	1,104.1	1,110.3
Colorado	121.7	65.5	56.2
Connecticut	203.2	107.3	95.9
Delaware	22.2	11.6	10.6
District of Columbia	119.5	60.0	59.5
Florida	236.2	133.4	'102.8
Georgia	334.2	218.9	'115.3
Guam	1.7	.9	.9
Hawaii	66.3	32.7	35.6
Idaho	33.6	23.6	10.0
Illinois	843.9	452.2	391.7
Indiana	237.8	134.9	102.9
Iowa	158.8	90.7	68.1
Kansas	142.5	81.4	61.1
Kentucky	185.1	136.2	48.9
Louisiana	218.9	167.7	51.2
Maine	88.9	67.2	21.7
Maryland	262.5	132.2	130.3
Massachusetts	781.4	385.0	396.4
Michigan	836.2	422.0	414.2
Minnesota	379.5	212.4	167.1
Mississippi	136.4	109.8	36.6
Missouri	180.1	109.2	70.9
Montana	42.6	26.9	15.7
Nebraska	68.1	40.2	28.9
Nevada	22.1	11.2	10.9
New Hampshire	45.9	27.5	18.4
New Jersey	472.7	236.3	236.4
New Mexico	47.4	34.6	12.8
New York	3,033.2	1,521.5	1,511.7
North Carolina	255.0	171.0	84.0
North Dakota	34.1	19.3	14.8
Ohio	530.4	296.6	243.8
Oklahoma	207.7	139.6	72.1
Oregon	136.7	85.6	51.1
Pennsylvania	887.2	513.8	373.4
Puerto Rico	66.7	27.4	41.3
Rhode Island	102.6	61.9	40.7
South Carolina	143.9	104.5	39.4
South Dakota	32.1	21.9	10.2
Tennessee	224.2	160.7	63.5
Texas	716.0	450.3	265.7
Utah	44.5	37.6	4.9
Vermont	44.3	32.0	12.3
Virgin Islands	1.6	1.4	.2
Virginia	232.1	145.6	86.5
Washington	222.2	127.3	95.9
West Virginia	63.3	45.5	17.8
Wisconsin	505.4	312.3	193.1
Wyoming	8.4	5.1	3.3
Total	16,357.0	9,181.5	7,128.1

[1] This includes only medical assistance payments that are computable for Federal matching. This differs from the amount reported in Table 21 because expenditures for persons or services not covered under the terms of the Federal law are not included. See explanation preceding Table 21.

[2] Federal and State shares reflect actual expenditures. They differ from amounts calculated using Federal medical assistance percentages because of corrections made for past overpayments and underpayments and other adjustments.

[3] No Title XIX program in effect.

TABLE 21.—FEDERAL, STATE AND LOCAL EXPENDITURES FOR MEDICAL ASSISTANCE, INCLUDING AMOUNTS NOT COMPUTABLE FOR FEDERAL MATCHING, FISCAL YEAR 1977

(in millions of dollars)

State	Total medical assistance payments [1]	Federal share	State share	Local share
Alabama	196.8	144.1	52.7	----
Alaska	18.2	10.4	7.8	----
Arizona [2]	----	----	----	----
Arkansas	150.3	110.1	40.2	----
California	2,618.0	1,104.0	1,241.0	373.0
Colorado	121.7	66.1	55.6	----
Connecticut	204.8	107.2	97.6	----
Delaware	22.2	12.0	10.2	----
District of Columbia	120.3	60.0	59.5	1.0[3]
Florida	239.6	133.4	106.2	----
Georgia	335.8	218.0	116.8	----
Guam	1.8	.9	.9	1.0
Hawaii	79.8	33.0	46.8	----
Idaho	33.3	24.0	9.3	----
Illinois	888.4	452.2	436.2	----
Indiana	239.3	135.0	104.3	----
Iowa	160.5	91.0	79.5	----
Kansas	164.5	81.4	85.1	----
Kentucky	185.2	136.2	49.0	----
Louisiana	220.4	167.6	52.8	----
Maine	89.1	67.1	22.0	----
Maryland	306.6	132.2	169.9	4.5
Massachusetts	781.4	385.0	396.4	----
Michigan	827.6	422.7	404.9	----
Minnesota	379.5	212.3	142.8	14.4
Mississippi	136.7	109.8	26.9	----
Missouri	188.3	109.1	79.2	----
Montana	43.0	26.8	16.2	----
Nebraska	68.4	40.2	16.4	11.9
Nevada	23.0	11.2	9.5	2.3
New Hampshire	46.0	27.4	18.6	----
New Jersey	481.1	236.3	244.8	[4]
New Mexico	47.5	34.6	12.9	----
New York	3,286.0	1,521.5	1,196.0	568.5
North Carolina	259.0	171.9	75.1	12.1
North Dakota	34.0	19.2	14.4	.4
Ohio	532.8	296.6	236.2	----
Oklahoma	207.7	139.6	68.1	----
Oregon	143.0	86.0	57.0	----
Pennsylvania	1,041.0	514.0	527.0	----
Puerto Rico	94.8	27.4	67.4	----
Rhode Island	102.6	62.0	40.6	----
South Carolina	146.6	105.0	41.6	----
South Dakota	32.7	21.8	10.9	----
Tennessee	224.2	160.6	63.6	----
Texas	716.2	430.2	260.0	----
Utah	44.9	37.5	7.4	----
Vermont	43.6	31.8	11.8	----
Virgin Islands	1.8	1.4	.4	----
Virginia	235.1	145.6	89.5	----
Washington	242.8	127.3	115.5	----
West Virginia	64.0	45.5	18.5	----
Wisconsin	505.0	312.3	192.7	----
Wyoming	7.7	5.0	2.7	----
Total	10,128.8	9,829.1	5,431.0	989.1

[1] Includes funds not computable for Federal matching. This accounts for the difference between this total and the total reported in Table 20. Payments not computable for Federal matching include expenditures to provide medical assistance to (a) persons who are financially eligible but not a member of one of the eligible categories of persons covered under the law (that is, they are persons between the ages of 21 and 65 who are not blind or disabled or AFDC parents) or (b) people whose income exceeds the income standards established in the State plan or the maximum level allowed for the medically needy by the Federal law.

[2] No Title XIX program in effect.

[3] Local funding represents money collected from local taxes rather than Congressional appropriations.

[4] Required local contribution in New Jersey is to administrative cost of the program; no amount reported as medical assistance payments.

Source: State expenditure data.

in terms of persons or services covered, expenditures are often shifted over, in some proportion, to local sources. It should be further noted that the actual fiscal burden on local governments may be considerably greater than is reported in Table 21, since a number of the costs on local governments are not reflected in the Medicaid data—increased demands on public hospitals and nursing homes, etc.

C. FORMULAS FOR LOCAL FUNDING OF MEDICAID

The non-Federal share of Medicaid expenditures can be financed entirely out of State funds, or can be jointly financed by the State and localities. However, Title XIX provides that State funds must account for not less than 40 percent of the non-Federal share. In addition, it specifies that since FY 1970, the State must either fund 100 percent of the non-Federal share, or provide for a distribution of funds "which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan."

A number of States still require some local contribution in financing the non-Federal share of Medicaid expenditures. Table 22 indicates the formulas by which various States which require some local contribution to the cost of Medicaid determine what the local share is.

Table 22.—Formulas for local funding of Title XIX; Medical Vendor Payments

California.—Local government funding is derived from the property tax. Rates are set by the comptroller each year, with affluent counties being assessed more than poorer ones. County shares range from $.05 to $.60 per $100.00 valuation.

Florida.—Counties contribute funding in two areas:

(1) When inpatient hospital care days exceed 12 per admission, counties pay 35 percent of non-Federal share for cost of care beyond 12 days.

(2) When nursing home vendor payments exceed $170 per month, counties pay 35 percent of the non-Federal share of that amount above $170, but not more than $55 per patient per month.

Minnesota.—As of October 1978, all non-Federal share was split 40.266 percent State and 4.474 percent local, excluding costs for State facilities for the mentally retarded.

Nebraska.—Counties pay 20 percent of total Medicaid costs.

Nevada.—Local funding is derived from the property tax. Accord-

ing to State law, $.11 up to $5.00 per $100.00 valuation goes into Medicaid funds.

New Hampshire.—There is local funding for services for the aged and disabled:

(1) For nursing home costs for the aged and disabled, legally liable units (i.e., cities, towns, or counties) pay 50 percent of the non-Federal share.

(2) For all other services for the aged and disabled, legally liable units pay $6 per month per old age recipient and $23 per month per APTD recipient.

New Jersey.—Counties pay 25 percent of total cost for EPSDT outreach programs and 10 percent of total cost for family planning. For these services, local funds constitute all non-Federal funds.

New York.—Counties pay 50 percent of non-Federal share.

North Carolina.—Counties pay 4.83 percent of State share except 11.27 percent for skilled nursing and intermediate care facilities (excluding intermediate care facilities for the mentally retarded).

North Dakota.—Counties pay 15 percent of State share.

Pennsylvania.—Counties paid total non-Federal share for Title XIX recipients in county nursing homes through FY 1976. The State is planning to take over these costs gradually, and will pay 90 percent of the non-Federal share in FY 1980.

South Dakota.—State law requires counties to pay $60.00 per month per public assistance and Medicaid recipient who has been admitted to State mental hospitals. Reimbursement for such hospital claims is reduced by $60.00 to reflect the State agency's share of the claims.

D. STATE MEDICAID EXPENDITURES, BY TYPE OF SERVICE

The distribution of expenditures for services varies substantially from State to State. Table 23 breaks out total Medicaid benefits for the major types of service in each State. Table 24 presents the same data in terms of the percentages of total expenditures in each State for the major types of service. Table 25 shows, on the other hand, the proportion of dollars spent for each service represented by the expenditures of each State.

E. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES PROVIDED TO MEDICAID CHILDREN

Each State's Medicaid program must provide that early periodic screening, diagnosis, and treatment (EPSDT) services are available to all eligibles under 21 years of age. The treatment services available

under EPSDT can be within the limits of the State's plan of covered services, with the exception that eyeglasses, hearing aids, other kinds of dental care necessary for the relief of pain and infection and for restoration of teeth must be provided, whether or not such services are included under the State plan.

A penalty can be imposed on any State not providing the required EPSDT services, amounting to a one-percent reduction in Federal share of matching funds under the State AFDC program.

Table 26 displays comparative data for EPSDT children under age 21 and under age six years for each State for FY 1977. Detailed are expected screenings, based upon each State's periodicity schedule and relevant national averages from AFDC demographic data [1] versus annualized reported screenings given during FY 1977. Health assessment percentage rates are then expressed as the ratio of screenings given to screenings expected and percentages of individuals screened with at least one suspected condition are indicated. The remainder of the table indicates the percentages of individuals screened with the specified conditions of vision, hearing, dental, lead poisoning, and other. These percentages are expected to exceed 100 percent since they are an expression of the number of conditions found in those "individuals screened with at least one condition."

The terms screening, diagnosis, and treatment are defined as follows:

Screening is the use of procedures to sort out apparently well persons from those who may have a disease or abnormality and to identify those in need of more definitive study of their physical or mental problems.

Diagnosis is the determination of the nature or cause of suspected physical or mental abnormality through the combined use of health histories, physical, developmental and psychological examinations, and laboratory tests and X-rays. Although, in some instances, diagnosis may be made at the time of screening, it will usually be necessary for the patient to visit an appropriate practitioner or medical facility for definitive evaluation.

Treatment means physician's or dentist's services, hospital services, or any other Medicaid services to prevent, correct or ameliorate disease or abnormalities detected by screening and diagnostic procedures.

F. RELATIVE SIZE OF STATE MEDICAID PROGRAMS

The largest States, especially New York and California, account for a disproportionate share of total Medicaid expenditures. New York

[1] Findings of the 1973 AFDC Study. (SRS) 74-03767, AFDC-1 (73), January 1975.

accounts for 20.2 percent of all Medicaid expenditures, and California 12.3 percent, with the 10 largest State programs expending 66.2 percent of total program dollars. Tables 27 and 28 list the States in order of the size of the State programs.

TABLE 23.—TOTAL MEDICAID BENEFITS BY TYPE OF SERVICE, FISCAL YEAR 1977

(in millions of dollars)

State	Total (Federal and State)	Inpatient hospital		Intermediate care facility			Physicians' services	Dental services	Other practitioners' services	Outpatient hospital	Clinic	Lab and X-ray	Home health services	Drugs	Family planning services	Other care
		General hospital	Mental hospital	Skilled nursing facility	Mentally retarded	Other										
Alabama	183	46	-------	54	-------	30	20	4	1	5	--------	3	1	17	1	1
Alaska	19	2	-------	3	6	6	1	------	--------	--------	--------	--------	--------	--------	--------	--------
Arizona [1]	-------	-------	-------	-------	------	-------	-------	------	--------	--------	--------	--------	--------	--------	--------	--------
Arkansas	142	26	-------	12	16	51	13	3	--------	2	2	3	--------	14	--------	2
California	1,999	649	95	423	-------	23	297	77	36	111	13	67	2	135	43	27
Colorado	110	19	4	19	11	26	12	1	--------	7	--------	2	--------	9	--------	1
Connecticut	213	55	1	92	7	4	13	3	1	12	1	--------	1	12	--------	8
Delaware	24	7	1	-------	1	7	4	------	--------	2	--------	--------	--------	2	--------	--------
District of Columbia	118	63	-------	2	-------	13	13	1	1	10	5	--------	1	5	2	2
Florida	224	72	7	43	2	36	26	4	--------	9	--------	1	--------	23	1	1
Georgia	319	79	-------	53	27	64	35	8	--------	15	--------	--------	--------	29	2	6
Guam [2]	-------	-------	-------	-------	-------	-------	-------	------	--------	--------	--------	--------	--------	--------	--------	--------
Hawaii	74	16	-------	16	-------	9	14	7	1	3	--------	2	--------	5	1	1
Idaho	32	5	-------	5	5	8	4	1	--------	1	--------	--------	--------	2	--------	--------
Illinois	919	361	12	69	23	158	95	27	12	37	29	7	1	66	6	14
Indiana	234	49	1	29	-------	93	21	3	1	9	1	1	1	20	1	5
Iowa	157	27	-------	1	23	70	13	6	2	4	--------	--------	--------	9	1	1
Kansas	162	44	5	3	18	41	18	6	2	6	2	4	--------	11	1	2
Kentucky	184	52	2	24	11	37	24	6	1	8	3	--------	2	12	1	2
Louisiana	228	51	1	4	35	77	17	1	--------	6	3	3	--------	29	1	1
Maine	85	21	-------	2	-------	37	12	2	--------	4	--------	--------	1	6	1	1
Maryland	235	99	-------	33	3	32	18	5	--------	24	--------	--------	1	14	4	3
Massachusetts	708	256	19	92	65	115	42	18	6	40	8	3	7	27	2	9
Michigan	792	217	52	144	41	98	104	20	7	38	1	9	1	47	9	4
Minnesota	374	64	5	88	63	75	28	10	3	9	1	--------	1	17	2	7

Mississippi	127	33	-------	39	2	7	16	3	1	4	--------	--------	--------	20	1	--------
Missouri	181	57	3	4	23	42	19	6	1	6	--------	--------	--------	18	1	--------
Montana	42	8	-------	7	1	14	5	1	1	1	--------	--------	--------	2	--------	1
Nebraska	72	15	-------	3	8	28	4	1	1	2	1	1	--------	6	--------	1
Nevada	21	7	-------	6	-------	3	3	------	--------	1	--------	--------	--------	--------	--------	--------
New Hampshire	44	8	-------	1	3	21	4	1	--------	1	--------	--------	--------	3	--------	1
New Jersey	464	113	44	8	-------	142	50	19	3	35	3	2	2	30	4	7
New Mexico	46	15	-------	-------	2	10	7	2	1	2	1	1	--------	4	--------	1
New York	3,286	904	213	789	180	306	138	54	26	313	44	13	146	103	16	43
North Carolina	271	86	14	38	19	40	22	10	2	5	3	1	1	26	2	1
North Dakota	32	6	1	11	-------	6	2	1	1	--------	--------	1	--------	2	--------	1
Ohio	523	160	10	113	22	60	54	11	7	37	3	1	1	38	1	5
Oklahoma	203	52	-------	-------	23	88	20	2	--------	--------	--------	2	--------	6	--------	9
Oregon	133	26	4	3	23	37	17	4	1	5	--------	2	--------	6	2	4
Pennsylvania	1,002	319	-------	290	126	65	53	18	6	--------	42	8	2	61	--------	10
Puerto Rico	95	35	-------	-------	-------	-------	21	1	--------	--------	--------	4	--------	23	--------	10
Rhode Island	109	41	4	11	16	17	5	3	--------	4	--------	--------	--------	6	1	1
South Carolina	141	34	6	34	5	17	16	4	1	6	--------	2	1	12	2	2
South Dakota	31	5	-------	5	4	12	3	------	--------	--------	--------	--------	--------	1	--------	--------
Tennessee	217	46	-------	1	21	82	24	3	--------	10	1	--------	--------	27	1	1
Texas	619	111	-------	30	47	284	61	3	4	12	--------	10	1	49	3	5
Utah	49	11	1	8	6	10	3	2	1	2	2	--------	--------	3	--------	1
Vermont	41	9	3	1	2	13	5	1	--------	1	--------	--------	--------	3	1	--------
Virgin Islands	2	1	-------	-------	-------	-------	-------	------	--------	1	--------	--------	--------	--------	--------	--------
Virginia	245	60	10	7	33	69	26	4	2	13	1	--------	1	15	1	3
Washington	216	50	3	67	3	16	28	13	--------	7	7	--------	1	13	2	6
West Virginia	61	28	-------	-------	-------	13	7	1	2	--------	--------	--------	--------	7	--------	2
Wisconsin	485	78	9	124	46	97	46	16	14	18	--------	--------	1	22	2	11
Wyoming	8	2	-------	2	-------	3	1	------	--------	--------	--------	--------	--------	--------	--------	--------
Total [3,4]	16,300	4,597	531	2,808	974	2,610	1,503	400	148	850	178	156	179	1,018	120	226

[1] No Title XIX program in effect.
[2] Omitted due to incomplete reporting.
[3] Totals may vary from other tables due to differing reporting systems. See technical note (page 3).
[4] Columns may not add to totals due to rounding.

Source: Office of Policy, Planning and Research, Research Report B-5 (Fiscal Year 1977).

TABLE 24.—PERCENTAGE DISTRIBUTION OF MEDICAL VENDOR PAYMENTS BY TYPE OF SERVICE BY STATE, FISCAL YEAR 1977

State	Total (Federal and State) [1]	Inpatient hospital		Skilled nursing facility	Intermediate care facility		Physicians' services	Dental services	Other practitioners' services	Outpatient hospital	Clinic	Lab and X-ray	Home health services	Drugs	Family planning services	Other care
		General hospital	Mental hospital		Mentally retarded	Other										
Alabama	100.0	25.0	--	29.6	--	16.7	11.1	2.0	0.6	2.9	--	1.6	0.6	9.1	0.6	0.3
Alaska	100.0	10.2	2.5	13.5	32.0	28.7	7.1	2.1	0.5	1.7	0.2	0.1	0.1	--	0.5	1.0
Arizona [2]	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Arkansas	100.0	18.1	--	8.2	11.0	35.9	8.8	2.2	0.2	1.2	1.2	1.9	0.1	9.9	0.1	1.1
California	100.0	32.5	4.8	21.2	--	1.1	14.9	3.8	1.8	5.6	0.6	3.4	0.1	6.8	2.1	1.4
Colorado	100.0	16.9	3.4	17.0	9.6	23.7	10.6	1.4	--	6.5	--	1.7	0.2	8.0	0.3	0.7
Connecticut	100.0	26.0	0.7	43.4	3.4	2.1	6.2	1.5	0.2	5.8	0.6	0.1	0.3	5.7	--	4.0
Delaware	100.0	29.8	4.1	1.2	3.8	27.9	15.3	0.2	0.5	7.8	0.8	1.1	0.4	6.3	0.7	--
District of Columbia	100.0	53.2	--	1.3	--	11.4	10.8	1.0	0.9	8.2	4.7	0.3	1.1	4.4	1.3	1.4
Florida	100.0	31.9	3.0	19.2	1.0	16.2	11.5	1.7	0.1	4.0	--	0.3	0.1	10.3	0.4	0.4
Georgia	100.0	24.9	--	16.5	8.4	20.1	10.9	2.4	0.1	4.6	0.1	0.1	0.2	9.2	0.6	1.9
Guam [3]	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Hawaii	100.0	21.3	--	21.3	--	11.8	18.2	10.0	1.0	3.9	--	3.1	0.3	6.4	1.7	1.1
Idaho	100.0	16.4	--	15.4	16.6	25.7	11.3	2.1	0.5	3.3	0.9	0.5	0.2	5.2	0.5	1.4
Illinois	100.0	39.3	1.3	7.5	2.5	17.1	10.4	2.9	1.4	4.1	3.1	0.8	0.2	7.2	0.7	1.6
Indiana	100.0	21.0	0.5	12.4	--	39.8	9.0	1.4	0.5	3.7	0.2	0.3	0.5	8.4	0.3	2.0
Iowa	100.0	12.4	--	0.4	14.7	44.2	8.2	3.5	1.3	2.8	0.1	0.1	0.1	5.7	0.8	0.8
Kansas	100.0	27.0	2.9	1.8	11.2	25.2	10.9	3.8	1.3	3.4	1.4	2.2	0.1	7.0	0.8	0.9
Kentucky	100.0	28.0	1.0	12.9	6.2	20.0	13.2	3.1	0.5	4.1	1.9	0.1	1.0	6.5	0.6	1.0
Louisiana	100.0	22.3	0.3	1.8	15.4	33.7	7.3	0.3	--	2.4	1.4	1.4	0.2	12.9	0.2	0.4
Maine	100.0	24.8	--	2.2	--	43.3	13.5	1.9	--	4.8	--	--	0.7	7.2	0.6	0.9
Maryland	100.0	42.3	--	13.9	1.1	13.4	7.9	2.0	--	10.3	--	--	0.2	6.0	1.5	1.4
Massachusetts	100.0	36.1	2.7	13.0	9.2	16.2	6.0	2.5	0.9	5.7	1.1	0.4	1.0	3.8	0.3	1.2
Michigan	100.0	27.4	6.6	18.2	5.2	12.3	13.2	2.5	0.9	4.8	0.1	1.2	0.1	5.9	1.1	0.6
Minnesota	100.0	17.1	1.3	23.7	16.9	20.2	7.4	2.7	0.8	2.4	0.1	0.1	0.4	4.6	0.4	2.0

Mississippi	100.0	26.2	--	30.9	1.7	5.8	12.6	2.4	0.4	3.3	--	0.2	0.2	15.5	0.7	0.2
Missouri	100.0	31.4	1.9	2.2	12.8	23.5	10.6	3.3	0.4	3.1	--	0.1	0.1	9.8	0.8	0.1
Montana	100.0	18.4	0.7	15.8	1.4	33.8	12.0	3.5	2.5	2.4	--	0.1	0.4	5.3	0.5	3.2
Nebraska	100.0	20.3	0.7	4.4	11.6	39.3	5.9	2.0	0.9	2.4	1.3	1.6	0.4	7.8	0.5	0.8
Nevada	100.0	33.3	--	27.0	--	14.0	13.6	1.5	0.5	3.5	0.1	0.2	0.4	4.9	--	1.0
New Hampshire	100.0	19.5	--	2.2	6.3	47.3	9.0	1.8	1.1	3.1	0.6	0.2	1.0	6.3	0.1	1.5
New Jersey	100.0	24.4	9.6	1.6	--	30.6	10.9	4.2	0.6	7.7	0.7	0.4	0.5	6.4	0.9	1.6
New Mexico	100.0	32.9	--	0.5	5.0	21.5	14.3	3.4	1.5	4.1	2.0	2.5	0.4	9.1	0.9	2.0
New York	100.0	27.5	6.5	24.0	5.5	9.3	4.2	1.7	0.8	9.5	1.3	0.4	4.4	3.1	0.5	1.3
North Carolina	100.0	31.9	5.1	13.9	7.0	14.9	8.2	3.7	0.8	2.0	1.1	0.3	0.3	9.7	0.8	0.4
North Dakota	100.0	18.8	4.6	33.2	--	18.1	7.5	3.8	1.9	1.3	--	2.0	0.1	6.9	0.3	1.6
Ohio	100.0	30.6	2.0	21.5	4.3	11.4	10.3	2.1	1.3	7.1	0.6	0.3	0.2	7.3	0.3	0.9
Oklahoma	100.0	25.7	--	--	11.2	43.4	9.6	1.1	0.1	0.2	--	1.0	--	2.8	0.1	4.6
Oregon	100.0	19.5	2.6	1.9	17.1	28.0	12.5	3.1	0.6	3.7	--	1.8	0.1	4.6	1.5	3.0
Pennsylvania	100.0	31.8	--	29.0	12.6	6.5	5.3	1.8	0.6	--	4.2	0.8	0.2	6.1	--	1.0
Puerto Rico	100.0	36.7	--	--	--	--	22.6	1.2	--	--	--	4.4	--	24.5	--	10.5
Rhode Island	100.0	37.4	3.4	9.9	14.4	16.1	4.4	2.4	0.3	4.1	--	0.3	0.2	5.9	0.5	0.9
South Carolina	100.0	24.4	4.1	24.3	3.9	11.7	11.5	2.6	0.4	4.1	--	1.4	0.4	8.4	1.3	1.5
South Dakota	100.0	17.0	--	15.1	13.2	37.6	8.7	1.2	0.8	1.6	--	--	--	3.8	0.2	0.8
Tennessee	100.0	21.0	0.1	0.5	9.9	37.8	10.9	1.4	--	4.4	0.5	0.1	0.2	12.2	0.3	0.6
Texas	100.0	17.9	--	4.9	7.5	45.9	9.9	0.5	0.6	2.0	--	1.6	0.1	7.9	0.4	0.8
Utah	100.0	21.3	2.5	15.4	12.6	20.2	7.0	4.2	1.1	3.2	3.4	0.2	0.2	6.0	0.3	2.3
Vermont	100.0	21.4	6.8	3.2	5.3	31.8	13.3	2.7	0.4	3.7	--	1.2	1.2	7.2	1.3	0.5
Virgin Islands	100.0	39.6	--	--	--	--	2.4	0.6	--	40.4	--	--	0.3	10.5	0.1	6.0
Virginia	100.0	24.5	4.2	2.8	13.3	28.0	10.8	1.7	0.7	5.2	0.6	0.1	0.3	6.1	0.6	1.1
Washington	100.0	23.2	1.4	30.9	1.4	7.3	13.0	6.1	--	3.2	3.1	0.2	0.4	6.2	0.9	2.8
West Virginia	100.0	45.3	--	0.3	--	21.1	12.1	2.3	3.3	--	--	--	--	11.6	0.2	4.0
Wisconsin	100.0	16.0	1.9	25.6	9.5	20.1	9.5	3.4	2.8	3.7	--	--	0.1	4.6	0.5	2.3
Wyoming	100.0	22.2	--	22.8	--	35.5	12.2	2.5	0.8	2.9	--	0.1	0.2	--	0.7	--
Total	100.0	28.2	3.3	17.2	6.0	16.0	9.2	2.5	0.9	5.2	1.1	1.0	1.1	6.2	0.7	1.4

[1] Columns may not add to total due to rounding.
[2] No Title XIX program in effect.
[3] Omitted due to incomplete reporting.

Source: Office of Policy, Planning and Research, Research Report B-5 (Fiscal Year 1977).

TABLE 25.—PERCENTAGE DISTRIBUTION AMONG STATES, MEDICAID BENEFITS BY TYPE OF SERVICE, FISCAL YEAR 1977

State	Total (Federal and State)	Inpatient hospital		Skilled nursing facility	Intermediate care facility		Physicians' services	Dental services	Other practitioners' services	Outpatient hospital	Clinic	Lab and X-ray	Home health services	Drugs	Family planning services	Other care
		General hospital	Mental hospital		Mentally retarded	Other										
Alabama	1.1	1.0	---	1.9	---	1.2	1.3	0.9	0.7	0.6	---	1.9	0.6	1.6	0.9	0.2
Alaska	0.1	---	0.1	0.1	0.6	0.2	0.1	0.1	0.1	---	---	---	---	---	0.1	0.1
Arizona [1]	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Arkansas	0.9	0.6	---	0.4	1.6	2.0	0.8	0.8	0.2	0.2	0.9	1.7	---	1.4	0.1	0.7
California	12.3	14.1	17.9	15.0	---	0.9	19.8	19.2	24.6	13.1	7.1	43.0	1.0	13.3	35.7	12.1
Colorado	0.7	0.4	0.7	0.7	1.1	1.0	0.8	0.4	---	0.8	---	1.2	0.1	0.9	0.3	0.5
Connecticut	1.3	1.2	0.3	3.3	0.7	0.2	0.9	0.8	0.4	1.5	0.7	0.2	0.3	1.2	0.1	3.7
Delaware	0.1	0.2	0.2	---	0.1	0.3	0.2	---	0.1	0.2	0.1	0.2	0.1	0.1	0.1	---
District of Columbia	0.7	1.4	---	0.1	---	0.5	0.8	0.3	0.7	1.1	3.1	0.2	0.7	0.5	1.3	0.7
Florida	1.4	1.6	1.3	1.5	0.2	1.4	1.7	0.9	0.1	1.1	---	0.4	0.1	2.3	0.7	0.4
Georgia	2.0	1.7	---	1.9	2.8	2.5	2.3	1.9	0.2	1.7	0.2	0.2	0.3	2.9	1.7	2.7
Guam [2]	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Hawaii	0.5	0.3	---	0.6	---	0.3	0.9	1.9	0.5	0.3	---	1.5	0.1	0.5	1.1	0.4
Idaho	0.2	0.1	---	0.2	0.6	0.3	0.2	0.2	0.1	0.1	0.2	0.1	---	0.2	0.1	0.2
Illinois	5.6	7.9	2.3	2.4	2.4	6.0	6.3	6.8	8.4	4.4	16.1	4.5	0.8	6.5	5.0	6.3
Indiana	1.4	1.1	0.2	1.0	---	3.6	1.4	0.8	0.8	1.0	0.3	0.4	0.7	1.9	0.7	2.1
Iowa	1.0	0.6	---	---	2.4	2.7	0.9	1.4	1.4	0.5	0.1	0.1	0.1	0.9	1.1	0.5
Kansas	1.0	1.9	0.9	0.1	1.9	1.6	1.2	1.5	1.4	0.7	1.2	2.3	0.1	1.1	1.1	0.7
Kentucky	1.1	1.1	0.3	0.8	1.2	1.4	1.6	1.4	0.6	0.9	1.9	0.1	1.0	1.2	0.9	0.8
Louisiana	1.4	1.1	0.1	0.2	3.6	2.9	1.1	0.2	---	0.7	1.9	2.0	0.2	2.9	0.4	0.4
Maine	0.5	0.5	---	0.1	---	1.4	0.8	0.4	---	0.5	---	---	0.3	0.6	0.5	0.4
Maryland	1.4	2.2	---	1.2	0.3	1.2	1.2	1.2	---	2.9	---	---	0.3	1.4	3.0	1.5
Massachusetts	4.3	5.6	3.6	3.3	6.7	4.4	2.8	4.5	4.1	4.7	4.6	2.0	3.8	2.6	1.8	3.8
Michigan	4.9	4.7	9.8	5.1	4.2	3.7	6.9	5.0	4.6	4.5	0.4	5.9	0.5	4.6	7.2	1.9
Minnesota	2.3	1.4	0.9	3.1	6.5	2.9	1.8	2.5	2.1	1.1	0.3	0.1	0.7	1.7	1.4	3.3

Mississippi	0.8	0.7	--	1.4	0.2	0.3	1.1	0.8	0.3	0.5	--	0.2	0.1	1.9	0.7	0.1
Missouri	1.1	1.2	0.6	0.1	2.4	1.6	1.3	1.5	0.5	0.7	--	0.1	0.1	1.7	1.2	0.1
Montana	0.3	0.2	0.1	0.2	0.1	0.5	0.3	0.4	0.7	0.1	--	--	0.1	0.2	0.2	0.6
Nebraska	0.4	0.3	0.1	0.1	0.9	1.1	0.3	0.4	0.5	0.2	0.5	0.8	0.2	0.6	0.3	0.3
Nevada	0.1	0.1	--	0.2	--	0.1	0.2	0.1	0.1	0.1	--	--	0.1	0.1	--	0.1
New Hampshire	0.3	0.2	--	--	0.3	0.8	0.3	0.2	0.3	0.2	0.2	0.1	0.2	0.3	--	0.3
New Jersey	2.8	2.5	8.4	0.3	--	5.4	3.3	4.8	1.8	4.2	1.9	1.1	1.3	2.9	3.4	3.2
New Mexico	0.3	0.3	--	--	0.2	0.4	0.4	0.4	0.4	0.2	0.5	0.7	0.1	0.4	0.3	0.4
New York	20.2	19.7	40.0	28.1	18.5	11.7	9.2	13.6	17.4	36.8	24.4	8.1	81.2	10.1	13.0	18.9
North Carolina	1.7	1.9	2.6	1.3	1.9	1.5	1.5	2.5	1.5	0.6	1.6	0.5	0.4	2.6	1.9	0.5
North Dakota	0.2	0.1	0.3	0.4	--	0.2	0.2	0.3	0.4	0.1	--	0.4	--	0.2	0.1	0.2
Ohio	3.2	3.5	1.9	4.0	2.3	2.3	3.6	2.7	4.6	4.3	1.9	0.8	0.5	3.8	1.2	2.1
Oklahoma	1.2	1.1	--	--	2.3	3.4	1.3	0.5	0.2	0.1	--	1.3	--	0.6	0.2	4.2
Oregon	0.8	0.6	0.7	0.1	2.3	1.4	1.1	1.0	0.5	0.6	--	1.5	0.1	0.6	1.7	1.8
Pennsylvania	6.1	6.9	--	10.3	13.0	2.5	3.5	4.5	4.1	--	23.7	5.1	1.0	6.0	0.4	4.6
Puerto Rico	0.6	0.8	--	--	--	--	1.4	0.3	--	--	--	2.7	--	2.3	--	4.4
Rhode Island	0.7	0.9	0.7	0.4	1.6	0.7	0.3	0.7	0.2	0.5	--	0.2	0.1	0.6	0.4	0.4
South Carolina	0.9	0.7	1.1	1.2	0.6	0.6	1.1	0.9	0.4	0.7	--	1.3	0.3	1.2	1.5	1.0
South Dakota	0.2	0.1	--	0.2	0.4	0.5	0.2	0.1	0.2	0.1	--	--	--	0.1	0.1	0.1
Tennessee	1.3	1.0	--	--	2.2	3.1	1.6	0.8	--	1.1	0.6	0.1	0.2	2.6	0.5	0.6
Texas	3.8	2.4	--	1.1	4.8	10.9	4.1	0.8	2.5	1.4	--	6.2	0.4	4.8	2.1	2.2
Utah	0.3	0.2	0.2	0.3	0.6	0.4	0.2	0.5	0.4	0.2	0.9	0.1	0.1	0.3	0.1	0.5
Vermont	0.2	0.2	0.5	0.1	0.2	0.5	0.4	0.3	0.1	0.2	--	0.3	0.3	0.3	0.4	0.1
Virgin Islands	--	--	--	--	--	--	--	--	--	0.1	--	--	--	--	--	0.1
Virginia	1.5	1.3	1.9	0.3	3.3	2.6	1.8	1.1	1.2	1.5	0.8	0.1	0.5	1.5	1.2	1.2
Washington	1.3	1.1	0.6	2.4	0.3	0.6	1.9	3.3	--	0.8	3.8	0.2	0.5	1.3	1.6	2.7
West Virginia	0.4	0.6	--	--	--	0.5	0.5	0.3	1.4	--	--	--	--	0.7	0.1	1.1
Wisconsin	3.0	1.7	1.7	4.4	4.7	3.7	3.1	4.1	9.2	2.1	0.1	0.1	0.4	2.2	2.0	5.0
Wyoming	0.1	--	--	0.1	--	0.1	0.1	--	--	--	--	--	--	--	0.1	--
Total [3]	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

[1] No Title XIX program.
[2] Omitted due to incomplete reporting.
[3] Columns may not add to totals due to rounding.

Source: Office of Policy, Planning and Research, Research Report B-5 (Fiscal Year 1977).

TABLE 26.—EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES PROVIDED TO MEDICAID CHILDREN, BY STATE, FISCAL YEARS 1977, 1978

State	Number of Screenings 1978 (in thousands)	Number of Screenings 1977 [1] (in thousands)		Percentage of Individuals Screened with at least one Condition		Percentage of Individuals Screened with Specified Conditions				
	Total Individuals under age 21	Total Individuals under age 21	Individuals under age 6	Total Individuals under age 21	Individuals under age 6	Vision	Hearing	Dental	Lead Poisoning	Other
TOTALS	2,042	1,977	837	51.7	41.8	8.0	2.3	23.1	0.4	28.6
Alabama	47	39	16	74.4	64.9	4.8	1.6	59.7	(z)	25.7
Alaska	5	6	2	59.9	52.9	18.3	11.5	28.6	2.2	5.8
Arizona [2]	--	---	---	---	---	---	---	---	---	---
Arkansas	26	17	9	41.4	29.9	4.9	1.7	22.4	(z)	29.8
California	124	86	51	81.0	81.6	2.8	1.8	8.0	---	26.7
Colorado	36	33	19	41.8	27.8	12.1	1.3	15.9	(z)	24.8
Connecticut	37	35	23	65.1	62.4	2.6	2.1	3.6	1.5	65.1
Delaware	2	3	1	19.4	10.1	3.4	1.0	16.4	(z)	1.2
District of Columbia	4	5	3	47.1	43.4	5.6	3.6	16.8	2.4	36.6
Florida	69	70	32	71.8	60.4	9.6	3.1	50.5	(z)	11.1
Georgia	64	59	27	81.4	64.8	13.3	4.1	62.6	(z)	46.7
Guam [3]	--	---	---	---	---	---	---	---	---	---
Hawaii	8	7	3	41.5	36.8	2.9	3.6	11.4	---	16.6
Idaho	13	9	5	39.5	39.1	4.3	2.8	13.7	---	3.5
Illinois	111	128	70	36.0	15.9	---	---	35.2	---	3.8
Indiana	64	51	9	99.5	99.2	34.3	5.7	60.4	---	16.9
Iowa	21	21	9	20.3	20.1	1.5	0.4	5.6	0.2	14.9
Kansas	10	13	5	34.0	27.4	5.6	2.9	15.8	(z)	19.6
Kentucky	31	30	11	65.9	58.8	10.4	6.1	32.1	0.2	42.9
Louisiana	47	41	17	54.3	42.0	8.2	2.4	36.7	0.2	34.3
Maine	15	19	7	30.7	31.3	0.2	0.2	25.1	0.1	5.1
Maryland	22	13	7	52.7	51.6	8.8	4.7	26.5	0.7	52.3
Massachusetts	137	38	27	4.0	3.7	0.8	0.5	0.6	0.2	2.9
Michigan	106	103	43	50.3	44.9	9.5	3.1	23.4	3.7	31.3
Minnesota	16	12	5	43.8	53.0	6.6	4.0	8.5	0.2	39.2

Mississippi	70	48	14	90.8	86.5	15.3	2.1	60.6	---	56.7
Missouri	31	38	13	39.5	37.1	7.4	5.0	10.1	0.3	32.8
Montana	2	6	1	99.0	98.0	6.2	1.0	98.6	---	19.0
Nebraska	10	9	4	29.2	23.4	5.9	2.1	6.9	---	18.7
Nevada	4	4	2	68.4	46.0	23.6	4.6	47.2	---	31.0
New Hampshire	5	3	1	67.1	59.3	7.5	2.5	54.0	1.2	28.0
New Jersey	41	44	18	42.6	37.4	3.1	1.0	4.5	0.7	37.3
New Mexico	9	7	3	53.5	42.6	11.6	10.0	23.3	---	24.2
New York	136	144	93	25.9	19.4	2.5	1.0	6.2	0.5	25.1
North Carolina	69	38	23	31.7	25.7	1.4	0.5	4.2	(z)	2.8
North Dakota	3	3	1	86.5	80.9	18.9	17.9	55.8	---	57.5
Ohio	48	44	15	60.8	60.0	---	---	---	---	---
Oklahoma	11	13	4	52.6	44.4	9.6	2.5	15.1	0.2	25.2
Oregon	34	31	16	73.9	70.2	14.4	6.0	26.3	(z)	71.8
Pennsylvania	181	160	75	47.5	40.0	11.5	2.4	17.6	0.6	46.6
Puerto Rico	21	225	78	77.4	71.6	3.6	1.2	19.5	---	54.5
Rhode Island	15	10	6	13.4	11.2	0.6	0.2	1.0	(z)	11.5
South Carolina	25	27	9	70.5	52.1	13.2	4.2	47.3	0.1	31.8
South Dakota	4	3	2	14.5	9.3	3.1	0.6	2.7	---	9.5
Tennessee	55	46	15	79.5	53.1	27.6	2.5	65.8	(z)	28.1
Texas	100	117	44	28.1	25.5	10.7	2.3	(z)	0.3	28.1
Utah	5	6	3	26.0	24.0	3.1	1.5	4.0	(z)	20.0
Vermont	11	6	4	8.6	8.3	---	---	---	---	---
Virgin Islands	2	10	3	54.9	51.1	0.9	0.9	2.7	(z)	50.8
Virginia	34	31	15	30.9	23.0	4.8	1.4	10.4	0.1	0.6
Washington	45	44	27	67.1	65.2	1.6	2.4	3.4	(z)	41.3
West Virginia	[3]	19	10	51.1	39.4	10.4	4.9	28.1	(z)	49.6
Wisconsin	20	16	7	72.1	68.8	10.6	3.5	32.2	0.8	57.5
Wyoming	1	2	1	49.4	50.2	3.4	2.0	7.1	---	46.1

[1] Number of screenings was annualized by applying a factor of 1.1 to 11 months of data. z Less than 0.05 percent.
[2] Not applicable; no Title XIX program in effect.
[3] Information not available.

Source: State statistics submitted to the Office of Policy, Planning and Research.

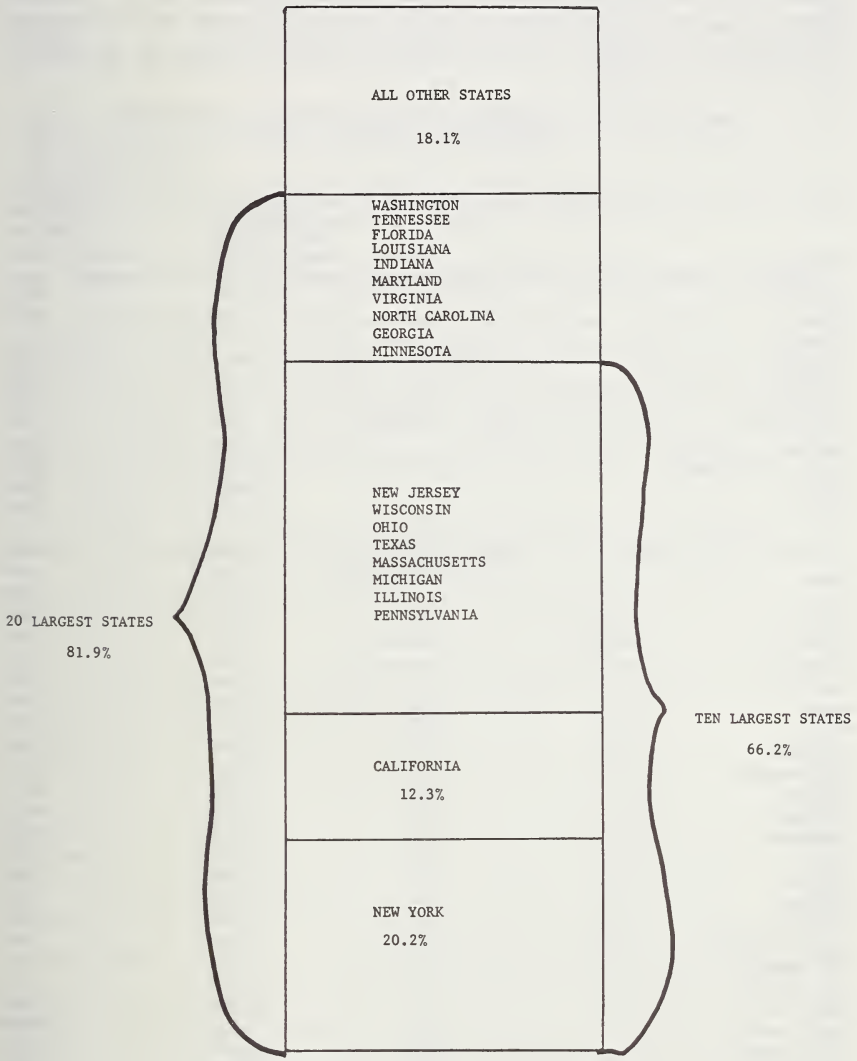
TABLE 27.—TOTAL MEDICAL VENDOR PAYMENTS IN ORDER OF SIZE OF STATE PROGRAMS, FISCAL YEAR 1977

State	Total benefits (in millions)	Percent of National total	Cumulative percent of National total
U.S. total [1]	**$16,300**	**100.0**	
New York	3,286	20.2	20.2
California	1,999	12.3	32.5
Pennsylvania	1,002	6.1	38.6
Illinois	919	5.6	44.2
Michigan	792	4.9	49.1
Massachusetts	708	4.3	53.4
Texas	619	3.8	57.2
Ohio	523	3.2	60.4
Wisconsin	485	3.0	63.4
New Jersey	464	2.8	66.2
10 Largest States	**10,797**	**66.2**	**66.2**
Minnesota	374	2.3	68.5
Georgia	319	2.0	70.5
North Carolina	271	1.7	72.2
Virginia	245	1.5	73.7
Maryland	235	1.4	75.1
Indiana	234	1.4	76.5
Louisiana	228	1.4	77.9
Florida	224	1.4	79.3
Tennessee	217	1.3	80.6
Washington	216	1.3	81.9
20 Largest States	**13,360**	**81.9**	**81.9**
Connecticut	213	1.3	83.2
Oklahoma	203	1.2	84.4
Kentucky	184	1.1	85.5
Alabama	183	1.1	86.6
Missouri	181	1.1	87.7
Kansas	162	1.0	88.7
Iowa	157	1.0	89.7
Arkansas	142	.9	90.6
South Carolina	141	.9	91.5
Oregon	133	.8	92.3
Mississippi	127	.8	93.1
District of Columbia	118	.7	93.8
Colorado	110	.7	94.5
Rhode Island	109	.7	95.2
Puerto Rico	95	.6	95.8
Maine	85	.5	96.3
Hawaii	74	.5	96.8
Nebraska	72	.4	97.2
West Virginia	61	.4	97.6
Utah	49	.3	97.9
New Mexico	46	.3	98.2
New Hampshire	44	.3	98.5
Montana	42	.3	98.8
Vermont	41	.2	99.0
Idaho	32	.2	99.2
North Dakota	32	.2	99.4
South Dakota	31	.2	99.6
Delaware	24	.1	99.7
Nevada	21	.1	99.8
Alaska	19	.1	99.9
Wyoming	8	.1	100.0
Virgin Islands	2	(2)	100.0

[1] Columns may not add to total due to rounding.
[2] Less than 0.05 percent.

Source: Office of Policy, Planning and Research, Research Report B-5 (Fiscal Year 1977).

TABLE 28.—TOTAL MEDICAID VENDOR PAYMENTS BY SIZE OF STATE PROGRAMS, FISCAL YEAR 1977



G. MEDICAID EXPENDITURES RELATIVE TO STATE INCOME LEVELS

Comparing State expenditures under Medicaid with personal income in the State provides a measure of the State's program relative to the wealth of the State. Table 29 provides both the total and the State share of Medicaid expenditures per $1 million personal income in the State.

TABLE 29.—SIZE OF STATE MEDICAID PROGRAM RELATIVE TO STATE INCOME LEVELS, FISCAL YEAR 1976

State	Total MVP [1] per $1,000,000 Personal Income	State Share of MVP per $1,000,000 Personal Income
Alabama	9,600	2,500
Alaska	3,300	1,700
Arizona	[2]	[2]
Arkansas	12,400	3,100
California	12,100	6,100
Colorado	7,000	3,200
Connecticut	8,600	4,300
Delaware	4,600	2,300
District of Columbia	17,900	8,900
Florida	3,800	1,600
Georgia	10,100	3,400
Guam	[3]	[3]
Hawaii	7,600	3,800
Idaho	7,200	2,300
Illinois	9,600	4,800
Indiana	6,600	2,800
Iowa	6,600	2,800
Kansas	7,700	3,500
Kentucky	8,600	2,500
Louisiana	10,000	2,800
Maine	13,700	4,000
Maryland	10,600	5,300
Massachusetts	16,600	8,300
Michigan	12,300	6,100
Minnesota	13,300	5,700
Mississippi	11,800	2,600
Missouri	4,400	1,800
Montana	7,400	2,700
Nebraska	5,900	2,600
Nevada	5,600	2,800
New Hampshire	7,400	2,900
New Jersey	7,700	3,800
New Mexico	6,500	1,700
New York	23,800	11,900
North Carolina	7,000	2,200
North Dakota	6,500	2,800
Ohio	6,900	3,200
Oklahoma	10,800	3,500
Oregon	7,000	2,900
Pennsylvania	8,700	3,900
Puerto Rico	[3]	[3]
Rhode Island	15,200	6,600
South Carolina	7,800	2,100
South Dakota	7,200	2,400
Tennessee	8,700	2,600
Texas	8,600	3,100
Utah	6,500	1,900
Vermont	15,100	4,600
Virgin Islands	[3]	[3]

TABLE 29.—SIZE OF STATE MEDICAID PROGRAM RELATIVE TO STATE INCOME LEVELS, FISCAL YEAR 1976—Continued

Virginia	6,000	2,500
Washington	7,500	3,500
West Virginia	6,600	1,900
Wisconsin	15,200	6,100
Wyoming	2,800	1,100
	10,500	4,700

[1] Medical Vendor Payments (MVP).
[2] No Medicaid program.
[3] Data not available.
Source: U.S. Department of Commerce—Survey of Current Business (January 1977), and actual State expenditures for public assistance programs, Fiscal Year 1976.

H. RELATIVE SIZE OF STATE MEDICAID RECIPIENT POPULATIONS

As with Medicaid expenditures, the largest States account for a great percentage of Medicaid recipients. California accounts for 13.8 percent, and New York for 13.1 percent, with the ten largest States accounting for 65.0 percent of total recipients. Tables 30 and 31 detail the number of Medicaid recipients in each State in order of the size of the State recipient populations.

TABLE 30.—TOTAL MEDICAID RECIPIENTS IN ORDER OF SIZE OF STATE MEDICAID POPULATIONS, FISCAL YEAR 1976

State	Total recipients (in thousands)	Percent of National total	Cumulative percent of National total
Total [1]	24,666	100.0	
California	3,393	13.8	13.8
New York	3,241	13.1	26.9
Pennsylvania	2,618	10.6	37.5
Illinois	1,461	5.9	43.4
Puerto Rico	1,451	5.9	49.3
Michigan	978	3.9	53.2
Massachusetts	837	3.4	56.6
Ohio	803	3.2	59.8
Texas	722	2.9	62.7
New Jersey	556	2.3	65.0
10 Largest States	12,667	65.0	65.0
Georgia	591	2.4	67.4
Wisconsin	516	2.1	69.5
Louisiana	428	1.7	71.2
Maryland	408	1.7	72.9
Kentucky	404	1.6	74.5
Florida	398	1.6	76.1
Tennessee	358	1.5	77.6
North Carolina	345	1.3	78.9
Alabama	321	1.3	80.2
20 Largest States	3,769	80.2	80.2
Virginia	320	1.3	81.6
Mississippi	299	1.2	82.8
South Carolina	293	1.2	84.0
Washington	274	1.1	85.2
Minnesota	269	1.1	86.4
Indiana	253	1.0	88.7

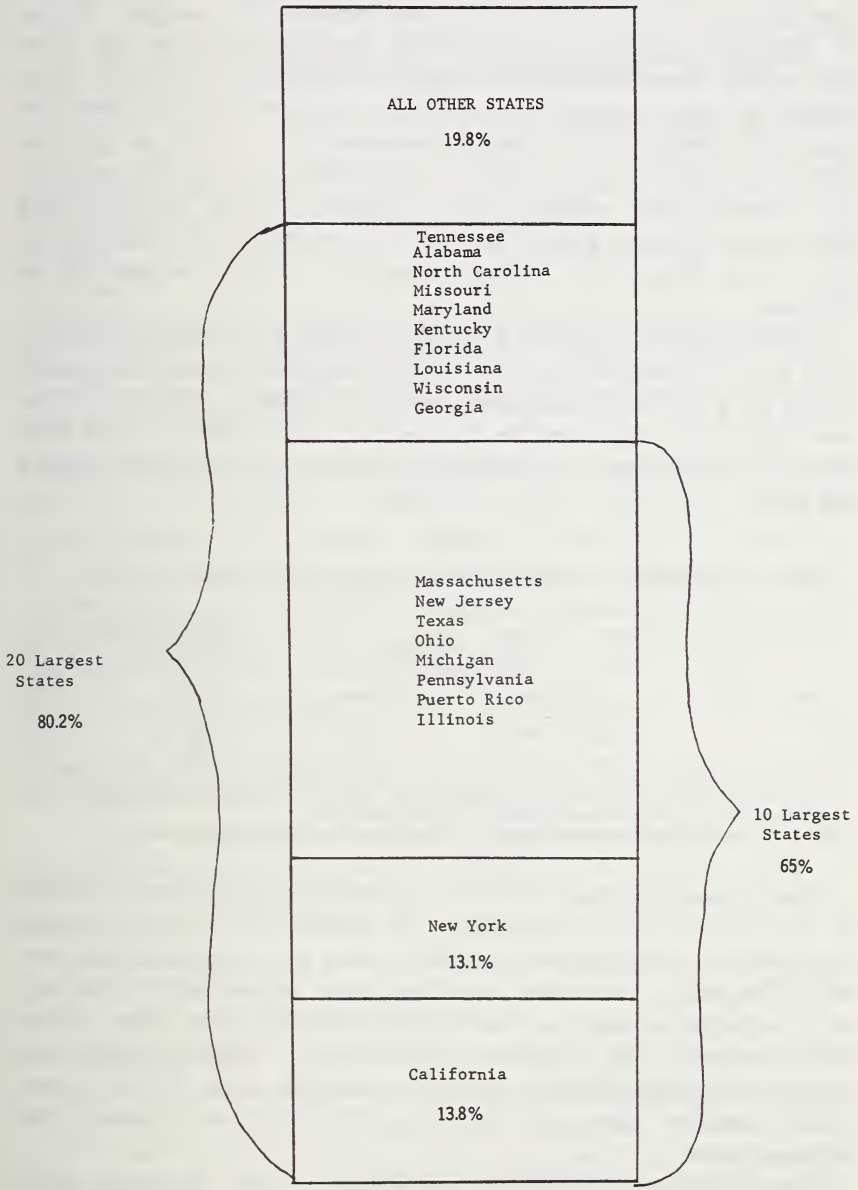
TABLE 30.—TOTAL MEDICAID RECIPIENTS IN ORDER OF SIZE OF STATE MEDICAID POPULATIONS, FISCAL YEAR 1976—Continued

Arkansas	220	.9	89.7
Oklahoma	210	.9	90.6
Connecticut	210	.9	91.5
West Virginia	192	.8	92.3
Oregon	189	.8	93.0
Colorado	180	.7	93.7
Kansas	179	.7	94.4
Iowa	154	.6	95.1
District of Columbia	152	.6	95.7
Maine	126	.5	96.3
Rhode Island	116	.5	96.8
Hawaii	114	.5	97.6
New Mexico	80	.3	97.9
Nebraska	70	.3	98.2
Utah	59	.2	98.4
Vermont	56	.2	98.6
Delaware	52	.2	98.8
New Hampshire	49	.2	99.0
Montana	41	.2	99.2
Idaho	41	.2	99.4
South Dakota	40	.2	99.5
North Dakota	26	.1	99.6
Nevada	26	.1	99.7
Virgin Islands	16	.1	99.8
Wyoming	13	.1	99.9
Alaska	9	.1	100.0

[1] Columns may not add due to rounding.

Source: Office of Policy, Planning and Research, Research Report B-4 (Fiscal Year 1976).

Table 31.—TOTAL MEDICAID POPULATION BY SIZE OF STATE PROGRAMS, FISCAL YEAR 1976



I. IMPACT OF MEDICAID ON THE USE OF HEALTH SERVICES BY THE POOR

Measurable increases in the utilization of medical services by the poor have occurred since Title XIX was enacted. For example, the use of physicians' services had historically been lower among the poor than among those with higher incomes. As Table 32 indicates, those defined as poor averaged 4.3 physician visits per year in 1964, the year before Medicaid was enacted, compared to 4.6 visits per year for those who were not poor. By 1977, both the poor and the non-poor had increased their average annual number of visits, but the poor made greater relative gains. The number of visits had increased to 5.6 per year for the poor in 1977, compared to 4.7 visits per year for the non-poor.

The percentage of persons who had not seen a physician in the previous two years declined from 1964-1977, with the decline being greater among the poor than among the non-poor, as shown in Table 32. However, despite their larger relative change, the poor in 1977 were still more likely than the non-poor to have had no physician contact in the previous two years.

TABLE 32.—COMPARATIVE USE OF HEALTH SERVICES BY THE POOR AND NONPOOR, 1964 AND 1977

Year	Number of physician visits per person per year		Percent of persons with no physician visits in the past 2 years	
	Poor [1]	Not poor	Poor [1]	Not poor
1964	4.3	4.6	27.7	17.7
1977	5.6	4.7	14.0	13.0

[1] Definition of poor is based on family income: under $3,000 in 1964, and under $7,000 in 1977. In each case, this accounts for approximately 1/3 of the population.

Source: National Center for Health Statistics. Health, United States, unpublished data.

These overall increases in the use of health services were not shared by all of the low income population. In addition, they are not adjusted to account for the differences in health status of the poor and the non-poor. The gains in utilization have been most pronounced for the poor who receive public assistance and are eligible for Medicaid; those without public assistance still lag behind in their use of health services. One study adjusted physician visits per year for health status, family income, public assistance status, and age group. The results are shown in the following table.

These differences in utilization among the poor depending upon their public assistance status are also reflected in estimates of the number of poor persons not receiving Medicaid benefits. Data published from *Health, United States*[1] in 1978, indicates that for a family with an

[1] *Health, United States,* 1978, DHEW.

income below $5,000, only 21% are without any form of insurance. The other 79% are covered by Medicaid, Medicare, private insurance and a combination of all three programs.

TABLE 33.—PHYSICIAN VISITS ADJUSTED FOR HEALTH STATUS BY FAMILY INCOME, PUBLIC ASSISTANCE STATUS, AND AGE GROUP, 1969

	All family incomes	Family income under $5,000		
		Total	Aid [1]	No aid
All persons	4.6	3.7	4.5	3.6
Under 17 years of age	3.3	3.0	3.5	3.0
Age 17 to 44	4.4	4.2	5.9	4.1
Age 45 to 64	4.9	4.0	5.2	3.9
Age 65 and over	6.6	6.1	6.4	6.1

[1] Aid includes all persons receiving public assistance. It should be noted that this includes some persons receiving public assistance in States which did not have Medicaid programs in 1969, and excludes persons covered under State only Medicaid programs and medically needy.

Source: Davis, Karen. "Medicaid Payments and Utilization of Medical Services by the Poor." Inquiry, Vol. XIII, No. 2, June 1976.

These estimates are meant to emphasize that a significant portion of the poor are not eligible for Medicaid coverage under the terms of the current program. The estimates should be used with care, however. First, they are based on very imperfect data. Second, the poverty standard applied to these Medicaid eligibles does not take into account any value for the Medicaid and other in-kind benefits these persons receive.[2] Third, because of work disregards and other factors, the incomes of welfare recipients may be quite different from the overall standard of need used in the State's assistance program.

There are three major reasons for the differences between the Medicaid population and the poverty population:

The poverty population is estimated according to a standard nationwide definition, with variations for individuals and families based on their size, composition, sex and age of family head, and farm/non-farm residence.

Medicaid standards are set by the States, with income levels which can be far below or far above the poverty level. For example, as of January 1978, the majority of States with medically needy programs had established their medically needy standards below the weighted average poverty thresholds determined by the Bureau of the Census in 1976. Only 6 of the 33 States and jurisdictions with medically needy programs had medically needy levels for one person in excess of the poverty thresholds for persons age 65 and over. Only five States had standards in excess of the poverty threshold for two persons, and none

[2] For a discussion of this issue, see the study prepared by the Congressional Budget Office, Background Paper No. 17, Poverty Status of Families Under Alternative Definitions of Income, January 1977.

of the States had a standard in excess of the poverty threshold for a four-person family.

Linkage of Medicaid to the welfare programs ties eligibility to the previously discussed categories of aged, blind, disabled, and members of families with dependent children. Others, including single adults and childless couples between the ages of 21 and 64, cannot become eligible for federally-matched Medicaid even if they fall below the income and resource levels.

The relationship between the Medicaid population and the poverty population also varies greatly among the States. The most recent data on a State-by-State basis is 1970.

Table 34, which compares the number of Medicaid recipients in each State with the number of persons falling under the nationwide poverty definition, shows that Medicaid recipients comprise 8 percent of the total population and 59 percent of the poverty population. The range, however, is extreme, with Medicaid recipients totaling less than 20 percent of the poverty population in eight States (Alabama, Arkansas, Mississippi, South Carolina, South Dakota, Tennessee, Texas, and Wyoming), and a number that is more than 100 percent of the poverty population in two States (California and New York.) Again, it should be remembered that even in States with a number of Medicaid recipients that exceeds the number of persons in poverty, a substantial number of the poor do not receive Medicaid if they do not fit into one of the covered eligibility categories.

TABLE 34.—MEDICAID RECIPIENTS COMPARED TO POVERTY POPULATION, 1970

State	Medicaid recipients (unduplicated annual count) as a percent of—	
	Total State population	Total State low-income population
Alabama	4	17
Alaska	[1]	[1]
Arizona	[1]	[1]
Arkansas	3	10
California	19	174
Colorado	7	61
Connecticut	5	75
Delaware	6	61
District of Columbia	15	91
Florida	8	27
Georgia	7	35
Guam	[2]	[2]
Hawaii	8	95
Idaho	4	27
Illinois	6	55
Indiana	2	24

TABLE 34.—MEDICAID RECIPIENTS COMPARED TO POVERTY POPULATION, 1970—Continued

Iowa	4	36
Kansas	6	45
Kentucky	10	43
Louisiana	6	23
Maine	6	44
Maryland	8	76
Massachusetts	[2]	[2]
Michigan	5	54
Minnesota	6	57
Mississippi	6	16
Missouri	6	38
Montana	4	28
Nebraska	4	33
Nevada	4	44
New Hampshire	4	45
New Jersey	5	55
New Mexico	6	28
New York	17	156
North Carolina	[2]	[2]
North Dakota	4	24
Ohio	4	36
Oklahoma	8	46
Oregon	4	38
Pennsylvania	10	93
Puerto Rico	[2]	[2]
Rhode Island	10	96
South Carolina	4	16
South Dakota	3	17
Tennessee	4	19
Texas	3	18
Utah	5	46
Vermont	8	71
Virgin Islands	[2]	[2]
Virginia	3	21
Washington	8	84
West Virginia	8	35
Wisconsin	6	59
Wyoming	2	19
United States [3]	8	59

[1] No Medicaid recipients in 1970.

[2] Information not available for at least 1 of the factors—population, low income population, or Medicaid recipients.

[3] Adjusted for the States where information is not available.

Source: Population by States, U.S. Bureau of the Census, "U.S. Census of Population, 1970," Vol. 1, Pt. A.; Low Income Population by States, U.S. Bureau of the Census, "Current Population Reports," P-60, No. 86; Medicaid Recipients, National Center for Social Statistics, B-4 (Calendar Year 1970).

J. MEDICAID RECIPIENTS AND EXPENDITURES, BY ELIGIBILITY CATEGORY

The distribution of Medicaid recipients and expenditures by eligibility category reveals marked differences in utilization. The aged, blind, and disabled account for only 24.6 percent of total recipients but 62.4 percent of expenditures, while children under 21 comprise 43.2 percent of recipients but only 16.6 percent of expenditures. Tables 35 through 37 detail recipients and expenditures for each of the eligibility categories.

TABLE 35.—MEDICAID RECIPIENTS AND EXPENDITURES BY ELIGIBILITY CATEGORY, FISCAL YEAR 1976

Basis of eligibility	Recipients		Expenditures	
	Total (in thousands)	Percent of total	Total (in millions)	Percent of total
	24,666	100.0	$14,135	100.0
Aged	3,807	13.4	5,191	36.7
Blind	98	.4	86	.6
Disabled	2,663	10.8	3,549	25.1
Children under age 21	10,644	43.2	2,352	16.6
Adults in AFDC families	5,238	21.2	2,244	15.8

Source: Office of Policy, Planning and Research, Research Report B-4 (Fiscal Year 1976).

Table 36.—MEDICAID RECIPIENTS BY BASIS OF ELIGIBILITY, FISCAL YEAR 1976

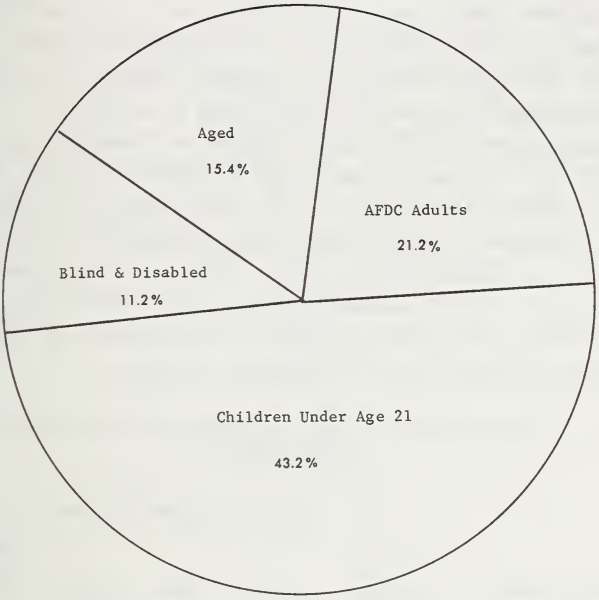
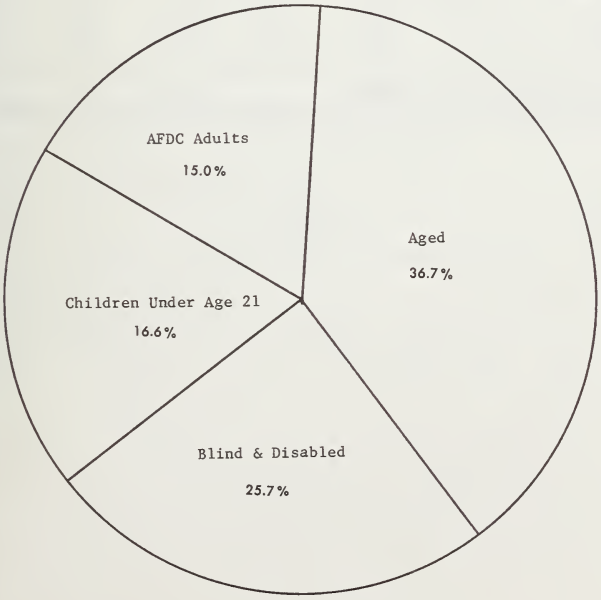


Table 37.—MEDICAID EXPENDITURES BY BASIS OF ELIGIBILITY, FISCAL YEAR 1976



K. MEDICAID EXPENDITURES FOR EACH ELIGIBILITY CATEGORY, BY TYPE OF SERVICE, FISCAL YEAR 1976

In addition to the differences in total expenditures among the eligibility categories, there are vast differences in expenditures for the major types of service within each of the eligibility groups. Tables 38 through 44 show, for each of the eligibility groups, the percentage of total expenditures made for the major types of service.

The expenditures for the aged eligible for Medicaid are related to coverage of the various services under Medicare for most of the same population. Small proportions of the expenditures for the aged are made for inpatient hospital care and physicians' services, reflecting the coverage of those services under Medicare, while the larger percentages going toward nursing home care, intermediate care, and prescribed drugs reflect the limitations on coverage, or lack of coverage, of those services under the Medicare program.

TABLE 38.—THE MEDICAID DOLLAR IS SPENT DIFFERENTLY IN EACH ELIGIBILITY CATEGORY, FISCAL YEAR 1976

Type of Service	Total recipients [1]	Basis of Eligibility				
		Aged	Blind	Disabled	Children under age 21	Adults in AFDC families
Total [1]	100.0	100.0	100.0	100.0	100.0	100.0
Inpatient hospital care	29.3	9.1	26.5	35.1	42.8	47.8
Skilled facility services	18.6	36.5	25.3	14.2	1.0	.4
Intermediate care facility services	21.3	37.3	21.0	25.6	2.9	.6
Physician services	12.1	4.3	9.4	9.1	22.3	23.5
Dental care	3.1	.8	1.5	1.6	9.0	4.9
Prescribed drugs	8.0	9.2	10.6	8.2	7.0	8.2
Other services	8.3	4.1	7.8	8.5	15.5	15.7

[1] Columns may not add due to rounding.

Source: Office of Policy, Planning and Research, Research Report B-4 (Fiscal Year 1976).

Table 39.—MEDICAID EXPENDITURES BY TYPE OF SERVICE FOR ALL RECIPIENTS, FISCAL YEAR 1976

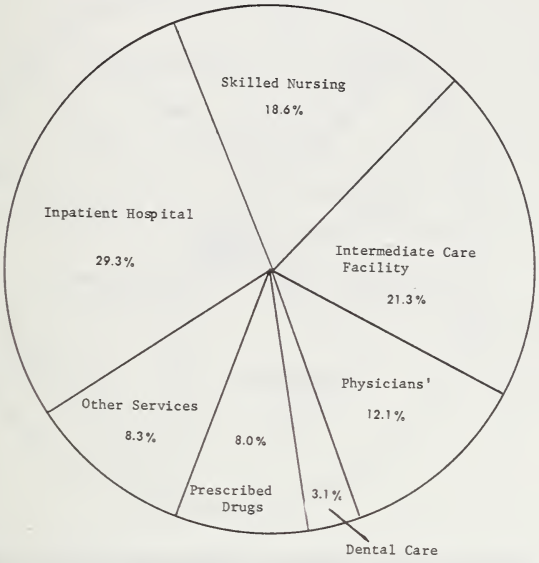


Table 40.—MEDICAID EXPENDITURES BY TYPE OF SERVICE FOR THE AGED, FISCAL YEAR 1976

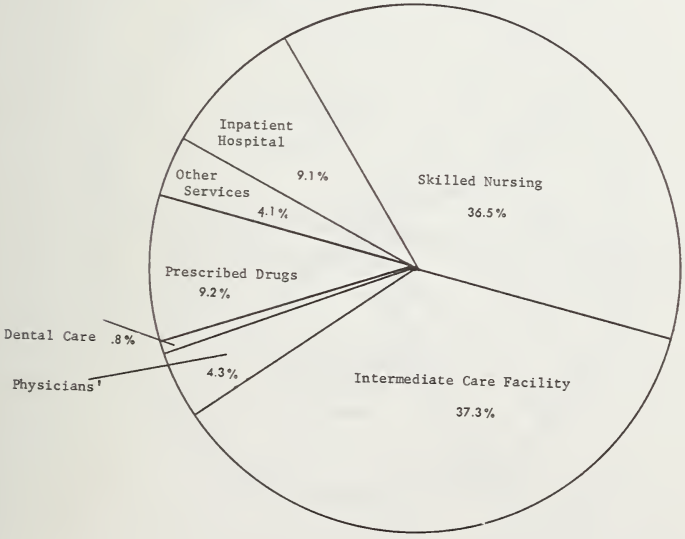


Table 41.—MEDICAID EXPENDITURES BY TYPE OF SERVICE FOR THE BLIND, FISCAL YEAR 1976

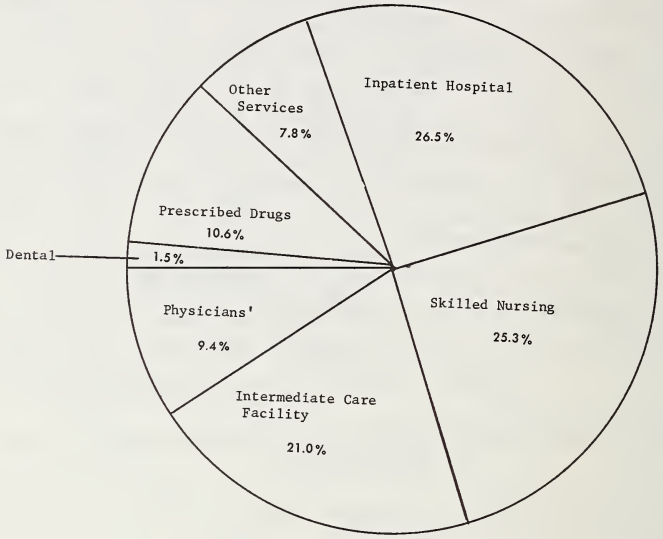


Table 42.—MEDICAID EXPENDITURES BY TYPE OF SERVICE FOR THE DISABLED, FISCAL YEAR 1976

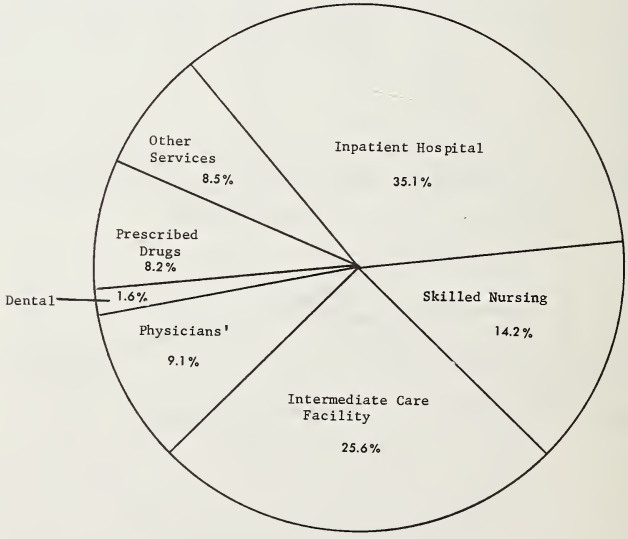


Table 43.—MEDICAID EXPENDITURES BY TYPE OF SERVICE FOR CHILDREN UNDER AGE 21, FISCAL YEAR 1976

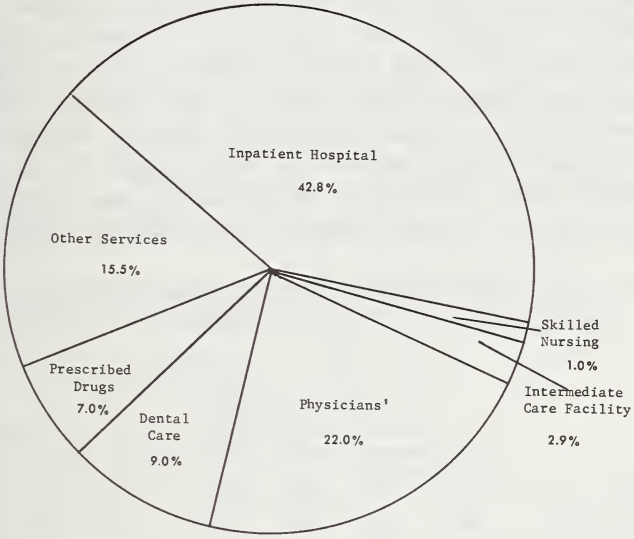
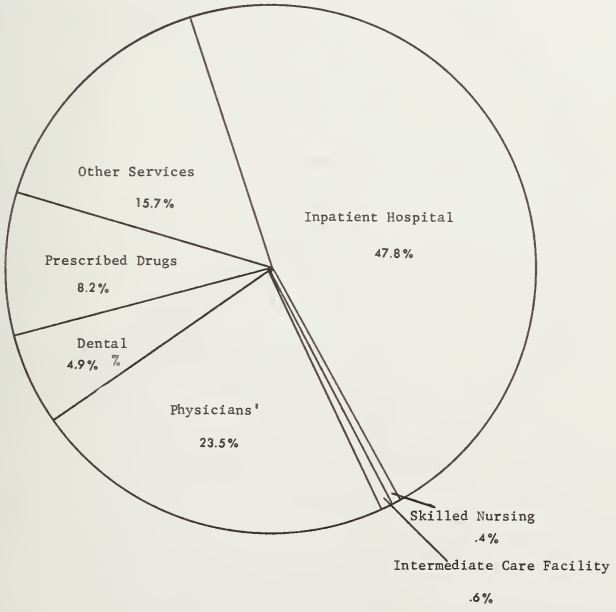


Table 44.—MEDICAID EXPENDITURES BY TYPE OF SERVICE FOR AFDC ADULTS, FISCAL YEAR 1976



L. MEDICAID EXPENDITURES FOR SELECTED SERVICES, BY ELIGIBILITY CATEGORY OF THE RECIPIENT

Tables 45 through 52 present the same data in terms of the percentage of total expenditures for each of the major types of service which are accounted for by the various eligibility categories. As might be expected, a relatively small proportion of inpatient hospital expenditures goes for the aged (because Medicare pays for most of this care), with the disabled, children under 21, and adults in AFDC families accounting for the major portions of inpatient hospital expenditures. Long term care expenditures go almost totally for the aged and the disabled, while expenditures for physicians' and dental services are made mostly for children under 21 and adults in AFDC families.

TABLE 45.—THE ELIGIBILITY CATEGORIES ACCOUNT FOR VARYING PERCENTAGES OF THE TOTAL SPENT ON EACH OF THE MAJOR MEDICAID SERVICES, FISCAL YEAR 1976

	Title XIX Services							
	Total	Inpatient hospital	Skilled nursing facility	Intermediate care facility	Physicians'	Dental	Prescribed drugs	Other
All Recipients [1]	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Aged	36.7	12.3	79.1	69.3	13.3	7.9	43.7	15.2
Blind and Disabled	25.2	32.5	19.6	3.2	18.7	11.1	25.6	22.3
Children	22.2	29.1	1.3	3.7	37.2	52.8	5.3	36.1
Adults in AFDC Families	18.9	28.4	.4	.4	33.4	37.2	19.2	30.2

[1] Columns may not add due to rounding.

Source: Office of Policy, Planning and Research, Research Report B-4 (Fiscal Year 1976).

Table 46.—MEDICAID EXPENDITURES FOR INPATIENT HOSPITAL CARE, BY BASIS OF ELIGIBILITY, FISCAL YEAR 1976

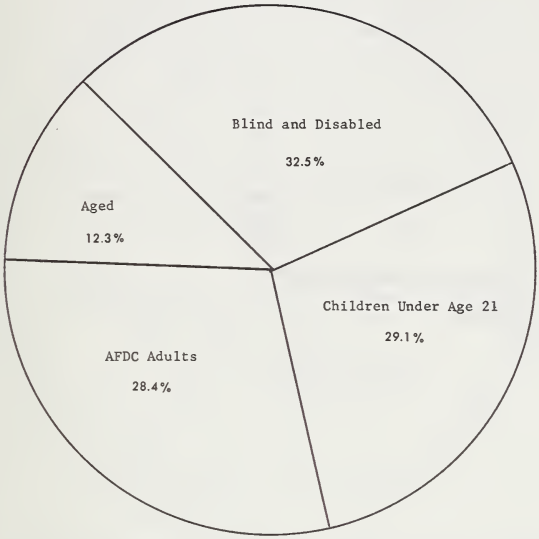


Table 47.—MEDICAID EXPENDITURES FOR SKILLED NURSING FACILITY CARE, BY BASIS OF ELIBILITY, FISCAL YEAR 1976

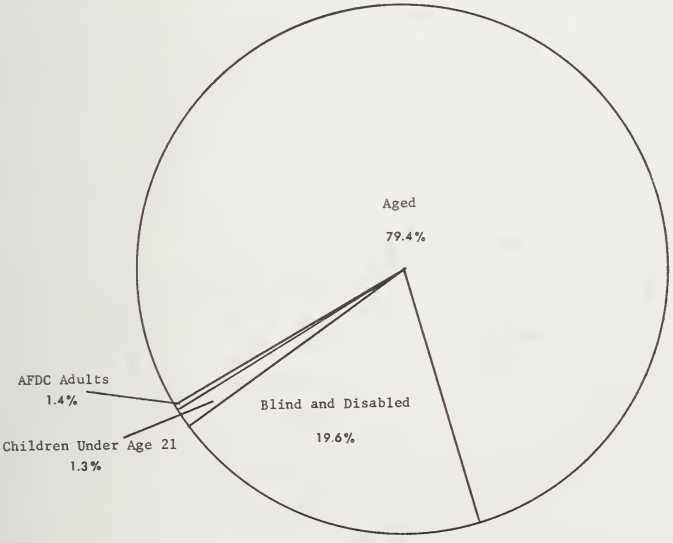


Table 48.—MEDICAID EXPENDITURES FOR INTERMEDIATE CARE FACILITY CARE, BY BASIS OF ELIGIBILITY, FISCAL YEAR 1976

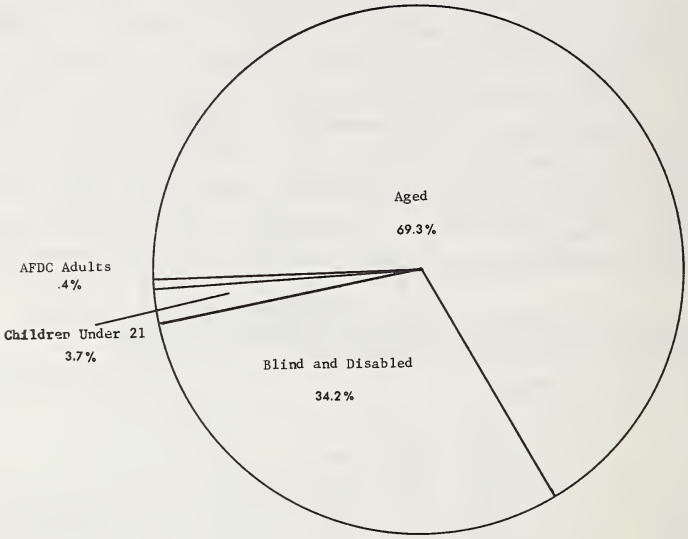


Table 49.—MEDICAID EXPENDITURES FOR PHYSICIANS' SERVICES, BY BASIS OF ELIGIBILITY, FISCAL YEAR 1976

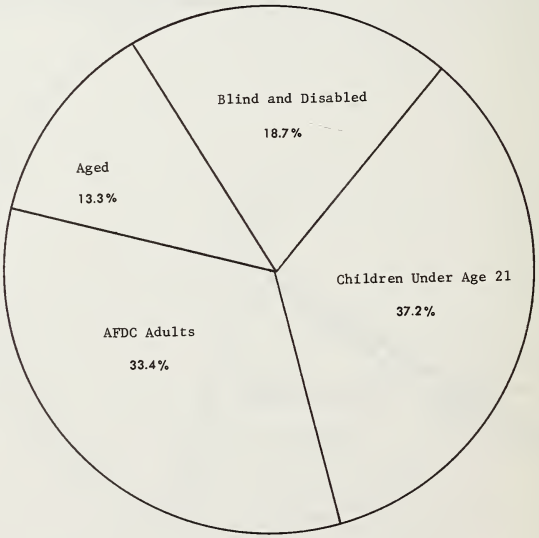


Table 50.—MEDICAID EXPENDITURES FOR DENTAL CARE, BY BASIS OF ELIGIBILITY, FISCAL YEAR 1976

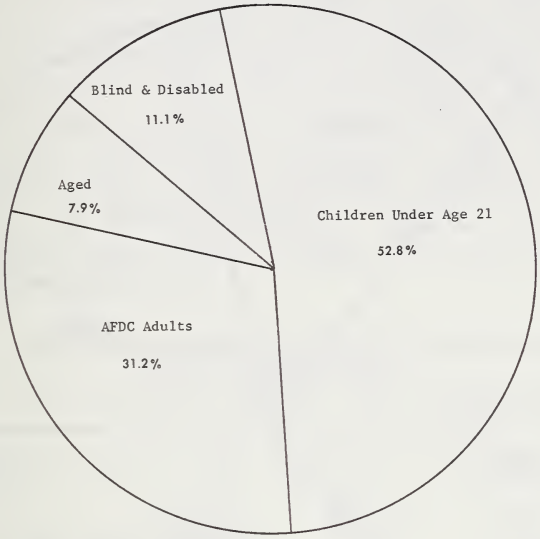


Table 51.—MEDICAID EXPENDITURES FOR PRESCRIBED DRUGS, BY BASIS OF ELIGIBILITY, FISCAL YEAR 1976

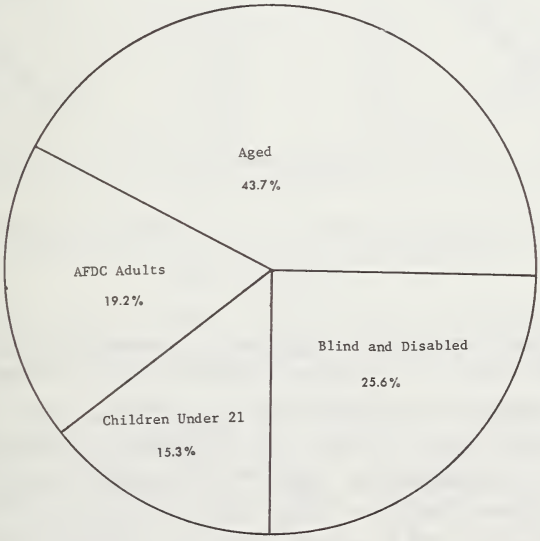
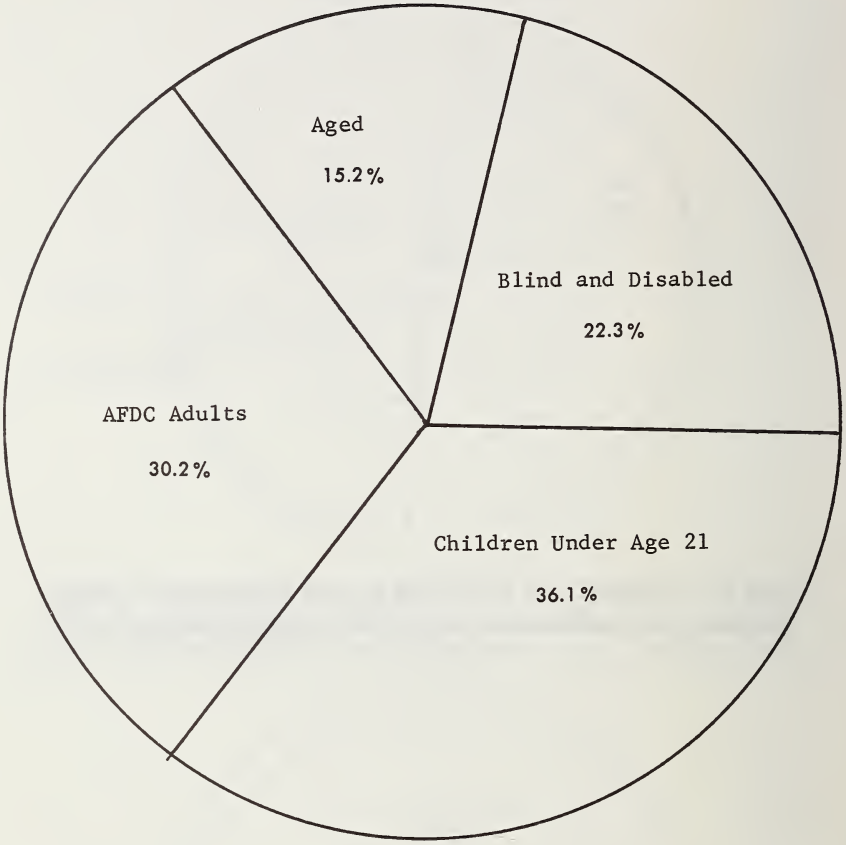


Table 52.—MEDICAID EXPENDITURES FOR OTHER CARE, BY BASIS OF ELIGIBILITY, FISCAL YEAR 1976



M. MEDICAID RECIPIENTS AND EXPENDITURES, BY MAINTENANCE ASSISTANCE STATUS OF RECIPIENT, FISCAL YEAR 1976

The distribution of recipients and expenditures differs greatly between those who also receive a cash assistance payment and those who do not. As indicated in Table 53, Medicaid recipients who are not cash assistance recipients make up 25.3 percent of total recipients, but account for 45.8 percent of total program expenditures. The difference is even more striking among the aged, with non-cash recipients accounting for 34.6 percent of recipients and 71.9 percent of expenditures for that group.

Medicaid recipients who are not cash assistance recipients include two major groups: (1) the medically needy, and (2) institutionalized persons who qualify for Medicaid because their special needs would

entitle them to a cash assistance payment if they were not inpatients in a medical institution. Such persons account for higher proportions of expenditures than their recipient numbers would indicate because they become eligible for Medicaid because of their high medical expenditures (they are already ill), and often because of their institutionalization. The group of non-cash Medicaid recipients thus preselects those persons in need of the most expensive forms of care. Other groups of Medicaid recipients who do not receive cash assistance include non-AFDC children in States which cover all children under 21, essential spouses of Medicaid recipients, children in foster care homes, and persons who could be eligible for cash assistance but have not applied for it.

TABLE 53.—RECIPIENTS AND PAYMENTS BY MONEY PAYMENT STATUS AND BASIS OF ELIGIBILITY, FISCAL YEAR 1976

Basis of Eligibility	Total	Money payment		Not authorized as percent of total
		Authorized	Not authorized	
RECIPIENTS				
Total	24,666,253	18,421,720	6,244,533	25.3
Aged	3,807,707	2,490,498	1,317,209	34.6
Blind	98,313	80,306	18,007	18.3
Disabled	2,663,724	2,116,048	547,676	20.6
Children under age 21	10,644,513	9,129,619	1,514,894	14.2
AFDC Adults	5,238,297	4,605,249	633,048	12.1
PAYMENTS (in millions)				
Total	14,134	7,657	6,477	45.8
Aged	5,191	1,456	3,734	71.9
Blind	86	55	31	35.9
Disabled	3,549	2,282	1,267	35.6
Children under age 21	2,352	1,903	449	19.1
AFDC Adults	2,244	1,960	284	12.6

Source: Office of Policy, Planning and Research, Research Report B-4 (Fiscal Year 1976).

N. MEDICAID RECIPIENTS AND PAYMENTS PER RECIPIENT IN EACH STATE BY BASIS OF ELIGIBILITY, AGE AND SEX

The following section (Tables 54-59) details the yearly number of recipients, and expenditures per recipient, in each State by basis of eligibility, by age, and by sex of the recipient.

Table 54 shows the number of recipients in each State in each of the eligibility categories, and Table 55 shows the average payment per recipient for each category. Expenditures per recipient for the aged, blind, and disabled are much higher than for adults and children in AFDC families by State.

Table 56 details the number of Medicaid recipients in specified age groups, with Table 57 showing the expenditures per recipient for the various ages. The average payment increases with age for the four age groups.

TABLE 54.—UNDUPLICATED YEARLY NUMBER OF RECIPIENTS BY BASIS OF ELIGIBILITY, FISCAL YEAR 1976

(in thousands) [1]

State	Total recipients	Aged	Blind	Disabled	Children under 21	AFDC adults
Alabama	322	110	2.0	48	111	49
Alaska	10	1	1.0	1	4	2
Arizona [2]	--	--	--	--	--	--
Arkansas	220	72	2.0	33	74	34
California	3,394	598	23.0	503	1,407	716
Colorado	180	38	.3	20	75	30
Connecticut	211	25	.3	19	124	42
Delaware	52	4	.3	3	32	11
District of Columbia	153	13	.2	13	85	41
Florida	398	92	2.2	66	164	73
Georgia	591	141	3.5	89	295	108
Guam [3]	--	--	--	--	--	--
Hawaii	114	10	.1	5	46	23
Idaho	42	7	.1	5	18	9
Illinois	1,461	98	2.0	188	804	367
Indiana	253	33	1.0	22	135	62
Iowa	155	32	1.0	13	64	39
Kansas	179	24	.5	14	69	30
Kentucky	404	75	2.0	48	69	30
Louisiana	429	126	2.0	64	162	69
Maine	126	18	.3	12	59	34
Maryland	408	46	.4	36	192	81
Massachusetts	837	126	8.6	61	345	161
Michigan	978	99	1.6	88	525	241
Minnesota	269	52	.8	31	114	51
Mississippi	299	87	2.0	31	135	43
Missouri	380	78	3.0	29	169	79
Montana	42	7	.3	6	18	8
Nebraska	70	15	.3	8	31	14
Nevada	26	4	.2	2	12	6
New Hampshire	49	10	.4	4	22	11
New Jersey	656	62	1.0	63	357	153
New Mexico	81	12	.3	12	41	16
New York	3,241	463	5.4	331	1,383	700
North Carolina	396	76	4.5	58	108	93
North Dakota	26	6	.5	3	10	5
Ohio	803	129	1.3	33	411	227
Oklahoma	210	56	.8	24	96	25
Oregon	189	20	1.2	19	96	52
Pennsylvania	2,618	175	6.9	235	1,002	663
Puerto Rico	1,451	23	.2	25	450	204
Rhode Island	116	32	.2	11	42	28
South Carolina	294	98	3.0	44	95	47
South Dakota	40	10	1.4	3	17	8
Tennessee	358	90	1.4	60	152	53
Texas	723	251	4.6	94	269	103
Utah	59	5	.1	5	31	15
Vermont	56	9	.1	6	26	13
Virgin Islands	16	1	.1	.1	4	1
Virginia	320	61	1.7	36	150	70
Washington	274	39	.7	38	111	59
West Virginia	192	30	.7	32	83	45
Wisconsin	516	104	1.2	51	255	102
Wyoming	13	2	.3	1	6	2
Total	24,650	3,795	94.0	2,647	10,508	5,148

[1] Number rounded to nearest thousand, unless less than one thousand.
[2] No Title XIX program in effect.
[3] Totals do not include Guam due to incomplete reporting.

NOTE: Columns may not add due to rounding.

Source: Office of Policy, Planning and Research, Research Report B-4 (Fiscal Year 1976).

Table 58 details Medicaid recipients by sex; nearly 2/3 of program recipients are female. Table 59, which provides average payment per recipient by sex, shows no great difference in expenditures for serv-

TABLE 55.—AVERAGE MEDICAID PAYMENT PER RECIPIENT BY BASIS OF ELIGIBILITY, FISCAL YEAR 1976

State	Total	Aged	Blind	Disabled	Children under 21	Adults in AFDC families
Alabama	488	616	623	725	139	383
Alaska	1,090	3,103	1,520	3,675	219	539
Arizona [1]	------	------	------	------	------	------
Arkansas	527	823	829	943	151	345
California	513	739	826	1,080	238	487
Colorado	988	1,077	1,915	1,596	172	477
Connecticut	913	3,477	1,687	2,303	275	638
Delaware	342	1,176	1,711	979	125	397
District of Columbia	691	1,412	1,126	1,956	366	720
Florida	442	930	510	664	158	323
Georgia	414	685	503	857	133	334
Guam [2]	------	------	------	------	------	------
Hawaii	462	1,728	926	1,104	190	462
Idaho	736	1,731	758	2,133	181	422
Illinois	509	1,694	373	566	237	401
Indiana	810	2,610	1,724	263	207	523
Iowa	779	1,896	1,085	1,743	223	494
Kansas	698	1,467	571	1,924	208	588
Kentucky	357	643	538	913	224	271
Louisiana	447	696	594	984	106	318
Maine	564	1,643	544	1,153	197	417
Maryland	554	1,354	744	1,178	242	519
Massachusetts	625	1,656	704	1,986	297	298
Michigan	919	1,965	1,169	1,962	270	733
Minnesota	1,181	2,631	1,815	3,451	243	638
Mississippi	1,370	656	524	721	125	299
Missouri	315	523	498	740	129	317
Montana	744	1,683	814	1,574	195	476
Nebraska	824	1,775	1,902	2,077	186	474
Nevada	850	1,496	1,352	2,844	263	756
New Hampshire	660	1,718	1,399	1,332	160	432
New Jersey	614	2,656	1,119	998	228	519
New Mexico	440	770	1,250	974	168	456
New York	1,032	2,787	2,140	2,199	424	633
North Carolina	492	807	720	101	129	292
North Dakota	944	2,264	1,228	1,680	212	473
Ohio	552	1,699	1,139	1,295	183	458
Oklahoma	766	1,294	1,066	1,696	287	506
Oregon	495	1,610	1,957	1,591	118	327
Pennsylvania	301	1,493	457	730	93	200
Puerto Rico	64	104	247	123	49	37
Rhode Island	776	1,252	1,330	2,542	197	365
South Carolina	353	451	533	579	131	363
South Dakota	618	1,334	599	1,480	163	330
Tennessee	491	840	643	920	157	449
Texas	815	1,294	421	1,625	195	549
Utah	580	2,003	1,237	1,996	153	334
Vermont	642	1,566	924	1,428	247	440
Virgin Islands	146	257	58	500	107	249
Virginia	559	1,183	841	1,222	198	446
Washington	650	1,668	878	1,335	190	498
West Virginia	311	473	372	533	168	306
Wisconsin	736	1,421	2,460	2,548	214	419
Wyoming	513	1,457	534	1,185	130	376
Total	606	1,641	934	1,324	185	416

[1] No Title XIX program in effect.
[2] Data not reported.

Source: Office of Policy, Planning and Research, Research Report B-4.

ices between males and females, with expenditures per female recipient approximately 15 percent higher than expenditures per male recipient.

TABLE 56.—RECIPIENTS OF MEDICAL VENDOR PAYMENTS UNDER MEDICAID BY AGE, FISCAL YEAR 1976

(in thousands)

State	Total recipients [2]	Number of recipients by age in years				
		Under 6	6 - 20	21 - 64	65 and over	Not reported
Alabama	322	46	83	70	123	
Alaska	10	2	4	3	1	
Arizona [3]						
Arkansas	220	27	60	59	75	
California	3,095	362	858	1,000	509	350
Colorado						
Connecticut						
Delaware	52	11	21	15	5	
District of Columbia	153	22	61	54	16	
Florida	398	69	113	113	102	1
Georgia	591	104	144	202	40	
Guam						
Hawaii	114	19	38	47	10	
Idaho	42	6	16	13	7	
Illinois	1,461	214	592	514	140	
Indiana	254	44	92	86	33	
Iowa	155	25	50	48	32	1
Kansas	180	31	62	61	27	
Kentucky	405	55	144	126	80	
Louisiana	429	54	106	101	91	78
Maine	126	16	44	48	18	
Maryland	409	53	143	160	54	
Massachusetts	838	156	322	233	127	
Michigan	979	169	585	315	110	
Minnesota	269	39	95	84	52	
Mississippi	300	37	100	74	89	
Missouri	381	50	132	110	89	
Montana	42	7	13	13	8	1
Nebraska	71	11	22	21	16	
Nevada	26	5	9	7	5	
New Hampshire	49	7	17	14	11	
New Jersey	656	111	275	202	68	
New Mexico	81	14	28	26	13	2
New York						
North Carolina	246	48	83	141	74	
North Dakota	26	4	9	7	7	
Ohio	803	144	289	280	92	
Oklahoma	211	35	65	53	57	
Oregon	190	33	67	69	21	
Pennsylvania	2,619	390	894	1,148	187	
Puerto Rico	1,451	349	503	575	24	
Rhode Island						
South Carolina	294	29	75	88	102	
South Dakota	40	7	12	10	11	
Tennessee	359	49	109	103	98	
Texas	723	92	189	181	261	
Utah	60	15	21	18	6	
Vermont	57	8	20	19	10	
Virgin Islands	16	3	4	8	1	
Virginia	320	46	115	96	63	
Washington						
West Virginia	193	26	57	74	36	
Wisconsin	519	84	184	137	110	1
Wyoming						
Total [1]	20,235	3,128	6,926	6,889	3,228	452

[1] Totals do not include Colorado, Connecticut, Guam, New York, Rhode Island, Washington or Wyoming.
[2] Totals may not add due to rounding.
[3] No Title XIX program.

Source: Office of Policy, Planning and Research, Research Report B-4 (Fiscal Year 1976).

TABLE 57.—AVERAGE MEDICAID PAYMENT PER RECIPIENT BY AGE, FISCAL YEAR 1976

State	All recipients [1]	Under 6	6-20	21-64	65 and over
Alabama	$487	$164	$188	$576	$759
Alaska	1,050	178	490	1,586	3,422
Arizona [2]	.....	.....	.....	.....	.....
Arkansas	529	183	187	645	829
California	533	264	303	776	972
Colorado	.....	.....	.....	.....	.....
Connecticut	.....	.....	.....	.....	.....
Delaware	344	164	109	514	1,222
District of Columbia	690	396	349	990	1,388
Florida	442	175	170	498	859
Georgia	414	99	228	485	258
Guam	.....	.....	.....	.....	.....
Hawaii	464	216	178	533	170
Idaho	731	192	301	993	168
Illinois	509	241	169	727	155
Indiana	809	304	213	891	290
Iowa	777	289	302	805	220
Kansas	698	234	380	633	220
Kentucky	357	170	191	477	642
Louisiana	236	447	135	189	806
Maine	564	193	199	613	165
Maryland	554	286	218	699	128
Massachusetts	625	262	243	833	166
Michigan	719	267	244	1,002	193
Minnesota	118	220	331	1,688	265
Mississippi	370	145	120	472	661
Missouri	315	173	124	427	539
Montana	736	270	335	860	168
Nebraska	818	234	225	109	172
New Hampshire	861	348	303	149	149
Nevada	662	208	165	572	167
New Jersey	614	322	236	650	250
New Mexico	441	196	203	675	747
New York	.....	.....	.....	.....	.....
North Carolina	691	463	270	476	788
North Dakota	620	185	188	641	134
Ohio	553	248	204	680	173
Oklahoma	766	282	831	964	126
Oregon	493	131	248	578	156
Pennsylvania	301	117	118	323	142
Puerto Rico	647	655	599	668	104
Rhode Island	.....	.....	.....	.....	.....
South Carolina	353	148	178	453	454
South Dakota	625	207	204	633	134
Tennessee	497	172	222	602	830
Texas	814	224	554	962	127
Utah	579	157	267	784	197
Vermont	640	264	306	698	150
Virgin Islands	147	147	89	160	430
Virginia	560	204	239	713	117
Washington	.....	.....	.....	.....	.....
West Virginia	310	181	169	402	437
Wisconsin	733	191	368	103	140
Wyoming	.....	.....	.....	.....	.....
Total [1]	$578	$235	$258	$656	$451

[1] Totals do not include Colorado, Connecticut, Guam, New York, Rhode Island, Washington or Wyoming.

[2] No Title XIX program in effect.

Source: Office of Policy, Planning and Research, Research Report B-4 (Fiscal Year 1976).

TABLE 58.—RECIPIENTS OF MEDICAL VENDOR PAYMENTS UNDER MEDICAID BY SEX, FISCAL YEAR 1976

(in thousands)

State	Number of Recipients By Sex		
	Total [2]	Male	Female
Alabama	322	112	210
Alaska	10	4	6
Arizona [3]	.....	.....	.....
Arkansas	221	80	141
California	3,095	828	2,162
Colorado	.....	.....	.....
Connecticut	.....	.....	.....
Delaware	52	20	33
District of Columbia	153	52	101
Florida	398	131	267
Georgia	591	197	394
Guam	.....	.....	.....
Hawaii	114	49	65
Idaho	42	15	27
Illinois	1,461	516	945
Indiana	254	85	168
Iowa	155	55	99
Kansas	180	71	109
Kentucky	405	156	249
Louisiana	429	122	229
Maine	129	61	65
Maryland	409	157	249
Massachusetts	839	268	561
Michigan	979	368	611
Minnesota	269	101	169
Mississippi	299	113	187
Missouri	381	133	247
Montana	42	16	23
Nebraska	70	25	45
Nevada	36	9	17
New Hampshire	49	17	32
New Jersey	658	239	416
New Mexico	81	30	51
New York	.....	.....	.....
North Carolina	346	119	227
North Dakota	26	10	17
Ohio	803	293	510
Oklahoma	211	28	133
Oregon	189	72	118
Pennsylvania	2,619	999	1,620
Puerto Rico	1,451	524	927
Rhode Island	.....	.....	.....
South Carolina	294	88	206
South Dakota	40	15	26
Tennessee	258	129	229
Texas	723	248	474
Utah	59	23	37
Vermont	57	22	35
Virgin Islands	16	6	10
Virginia	320	116	205
Washington	.....	.....	.....
West Virginia	193	116	205
Wisconsin	517	198	319
Wyoming	.....	.....	.....
Totals [1]	20,246	7,141	13,176

[1] Totals do not include Colorado, Connecticut, Guam, New York, Rhode Island, Washington or Wyoming.

[2] Totals may not add due to rounding.

[3] No Title XIX program.

Source: Office of Policy, Planning and Research, Research Report B-4 (Fiscal Year 1976).

TABLE 59.—AVERAGE MEDICAID PAYMENT BY SEX, FISCAL YEAR 1976

State	Total recipients	Male	Female
Alabama	$487	$388	$543
Alaska	1,050	1,273	976
Arizona [2]	.....	.....	.....
Arkansas	526	473	557
California	533	530	566
Colorado	.....	.....	.....
Connecticut	.....	.....	.....
Delaware	344	280	380
District of Columbia	690	655	716
Florida	442	366	482
Georgia	414	398	422
Guam	.....	.....	.....
Hawaii	464	413	503
Idaho	731	720	737
Illinois	509	486	521
Indiana	809	716	862
Iowa	777	674	840
Kansas	698	640	735
Kentucky	357	323	378
Louisiana	447	426	474
Maine	551	535	592
Maryland	554	502	589
Massachusetts	624	634	621
Michigan	719	600	792
Minnesota	1,068	1,177	1,201
Mississippi	372	301	413
Missouri	315	260	345
Montana	736	688	806
Nebraska	118	790	852
Nevada	861	827	878
New Hampshire	662	555	719
New Jersey	612	496	682
New Mexico	441	403	461
New York	.....	.....	.....
North Carolina	491	481	496
North Dakota	954	886	938
Ohio	553	455	609
Oklahoma	766	728	789
Oregon	496	474	505
Pennsylvania	302	293	306
Puerto Rico	64	72	60
Rhode Island	.....	.....	.....
South Carolina	353	315	369
South Dakota	625	575	655
Tennessee	492	443	519
Texas	815	776	833
Utah	589	565	587
Vermont	640	580	679
Virgin Islands	147	146	147
Virginia	560	508	587
Washington	.....	.....	.....
West Virginia	310	.....	.....
Wisconsin	736	788	738
Wyoming	.....	.....	.....
Totals [1]	$561	$546	$610

[1] Totals do not include data for Arkansas, Colorado, Connecticut, Guam, New York, North Carolina, Rhode Island, Washington or Wyoming.

[2] No Title XIX program in effect.

Source: Office of Policy, Planning and Research, Research Report B-4 (Fiscal Year 1976).

O. AVERAGE MEDICAID PAYMENTS FOR RECIPIENTS OF AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)

Previous tables have examined the average payment per Medicaid recipient for various groups of recipients. Table 60, which shows the average Medicaid payment per AFDC cash assistance recipient, provides a look at Medicaid expenditures for the average number *eligible* throughout the year, as opposed to expenditures for number of different *recipients*. This analysis provides a more accurate picture of the yearly value of the Medicaid benefit package, by eliminating the effect of persons coming on the rolls for limited periods of time, using services, and then going off the rolls.

Table 61 portrays the average payment per AFDC recipient in each State.

TABLE 60.—AVERAGE ANNUAL MEDICAID EXPENDITURES FOR AFDC CASH ASSISTANCE RECIPIENTS, FISCAL YEAR 1977

Recipients of cash assistance under AFDC	Average monthly number of recipients of AFDC [1]	Annual Medicaid expenditures for AFDC cash assistance recipients [2]	Average Medicaid payment for recipients of AFDC cash assistance
Children	7,522,500	$2,040,552,089	$271
Adults	3,183,800	$2,059,742,731	$647
Families [3]	3,436,200	$4,100,294,820	$1,193
Total	10,706,300	$4,100,294,820	$383

[1] ORS A-2 Reports for fiscal year 1977.
[2] Research Reports B-1 for fiscal year 1977.
[3] Average size of AFDC families: 3.1, including .9 adults and 2.2 children.

TABLE 61.—AVERAGE PAYMENT FOR PERSONS ELIGIBLE ON THE BASIS OF RECEIPT OF AID TO FAMILIES WITH DEPENDENT CHILDREN, FISCAL YEAR 1977

State	Families	Children	Adults
Alabama	820	160	560
Alaska	780	170	610
Arizona	.....	.....	.....
Arkansas	770	180	460
California	1,310	310	700
Colorado	(2)	(2)	(2)
Connecticut	940	240	450
Delaware	930	200	590
District of Columbia	1,740	400	990
Florida	700	160	450
Georgia	(2)	(2)	(2)
Guam	(2)	(2)	(2)
Hawaii	1,470	310	760
Idaho	1,200	260	750
Illinois	1,750	380	860
Indiana	1,130	240	730
Iowa	1,220	260	710
Kansas	1,400	320	1,040
Kentucky	700	150	400
Louisiana	690	130	450

TABLE 61.—AVERAGE PAYMENT FOR PERSONS ELIGIBLE ON THE BASIS OF RECEIPT OF AID TO FAMILIES WITH DEPENDENT CHILDREN, FISCAL YEAR 1977—Continued

Maine	1,080	330	410
Maryland	990	250	560
Massachusetts	1,170	380	390
Michigan	1,330	270	760
Minnesota	1,440	330	970
Mississippi	580	120	350
Missouri	670	150	410
Montana	1,190	270	800
Nebraska	980	210	620
Nevada	1,420	260	1,110
New Hampshire	1,090	220	700
New Jersey	1,310	280	690
New Mexico	1,010	210	590
New York	1,800	430	830
North Carolina	750	160	560
North Dakota	1,500	360	940
Ohio	1,080	220	650
Oklahoma	870	260	340
Oregon	950	280	440
Pennsylvania	1,060	210	610
Puerto Rico	220	50	50
Rhode Island	1,140	250	650
South Carolina	760	150	540
South Dakota	710	170	440
Tennessee	720	190	420
Texas	1,020	200	670
Utah	110	30	60
Vermont	1,530	410	600
Virgin Islands	220	50	160
Virginia	980	230	610
Washington	1,220	280	680
West Virginia	1,000	220	600
Wisconsin	1,350	370	680
Wyoming	940	230	670
Total [1]	1,190	270	650

[1] Totals adjusted for those States that did not report cash assistance recipients and/or vendor payments. Figures differ from Table 60 due to rounding.

[2] Information not available for one of the factors—cash assistance recipients or vendor payments.

Source: HCFA/MMB/DAE.

P. AVERAGE MEDICAID PAYMENT FOR PERSONS ELIGIBLE ON THE BASIS OF RECEIPT OF A FEDERALLY ADMINISTERED SUPPLEMENTAL SECURITY INCOME (SSI) PAYMENT

Determination of the average Medicaid payment per SSI cash recipient is more difficult than the determination of average Medicaid payment per AFDC recipient, because the automatic link between receipt of cash assistance and eligibility for Medicaid was eliminated for aged, blind, and disabled persons upon implementation of the SSI program. States can limit Medicaid coverage to some more restrictive aspect of their Medicaid eligibility standard in effect in January 1972, in lieu of covering all SSI recipients. In the States choosing to restrict their Medicaid eligibility (see Table 7), SSI recipients are not automatically eligible for Medicaid.

Table 62 examines the average Medicaid payment for the average number of persons eligible for SSI throughout the year, in those 35 States which extend Medicaid coverage to all SSI recipients.

TABLE 62.—AVERAGE MEDICAID PAYMENT FOR PERSONS ELIGIBLE ON THE BASIS OF RECEIPT OF A FEDERALLY ADMINISTERED SSI PAYMENT, FISCAL YEAR 1977

State	Aged	Blind	Disabled
Alabama	$600	$635	$837
Alaska	3,947	671	5,711
Arizona [1]	.....	.....	.....
Arkansas	471	770	1,206
California	598	840	1,554
Colorado [2]	.....	.....	.....
Connecticut [2]	.....	.....	.....
Delaware	1,194	722	1,414
District of Columbia	2,254	1,256	2,264
Florida	394	515	808
Georgia	[4]	[4]	[4]
Guam [3]	.....	.....	.....
Hawaii [2]	.....	.....	.....
Idaho	116	228	343
Illinois [2]	.....	.....	.....
Indiana [2]	.....	.....	.....
Iowa	883	642	2,362
Kansas	966	1,005	2,454
Kentucky	829	572	1,120
Louisiana	572	490	840
Maine	703	577	1,231
Maryland	739	548	1,019
Massachusetts	980	508	1,777
Michigan	860	986	1,865
Minnesota [2]	.....	.....	.....
Mississippi [2]	.....	.....	.....
Missouri [2]	.....	.....	.....
Montana	1,010	1,523	2,217
Nebraska [2]	.....	.....	.....
Nevada	2,215	828	2,872
New Hampshire [2]	.....	.....	.....
New Jersey	846	1,118	1,308
New Mexico	397	986	1,073
New York	1,756	1,211	1,725
North Carolina [2]	.....	.....	.....
North Dakota	957	376	1,317
Ohio [2]	.....	.....	.....
Oklahoma [2]	.....	.....	.....
Oregon	756	1,051	800
Pennsylvania	908	567	1,457
Puerto Rico [3]	.....	.....	.....
Rhode Island	1,480	1,517	2,441
South Carolina	592	701	913
South Dakota	764	915	1,755
Tennessee	499	606	834
Texas	787	832	1,330
Utah [2]	.....	.....	.....
Vermont	966	718	1,482
Virgin Islands [3]	.....	.....	.....
Virginia [2]	.....	.....	.....
Washington	579	730	1,138
West Virginia	612	447	662
Wisconsin	922	3,286	3,264
Wyoming	684	264	772

[1] No Title XIX program in effect.

[2] State does not provide Title XIX coverage to all SSI recipients.

[3] No SSI program in effect in these jurisdictions.

[4] Not Available.

Source: HCFA/MMB/DAE.

Q. ANNUAL NEED AND PAYMENT STANDARDS FOR AFDC FAMILIES

Persons receiving a cash payment under a State's AFDC program are automatically eligible for Medicaid. Each State must specify a need standard (representing the cost of basic essentials such as food, shelter, clothing, as determined by the State), and a payment standard, which may be equal to or less than the need standard. A State has alternatives in using a percentage reduction to establish a reduced payment standard. In one method, the reduction is applied to the full need standard, thereby creating a reduced payment standard. In this case, persons with countable income equal to or greater than the payment standard are ineligible as categorically needy even though their countable income may be below the State's full need standard. If the State has a medically needy program, such families may be covered as medically needy if their income (after deduction of incurred medical expenses) meets the State medically needy income level and providing they are otherwise eligible. States may also establish a reduced payment standard by applying the percentage reduction to the deficit (need standard less income).

Under Federal regulations, a State's medically needy income level (Table 64) may not exceed 133 1/3% of the highest money payment that would ordinarily be made under the State AFDC plan to a family of the same size without income and resources, rounded to the next higher multiple of $100.

Amounts in Table 63 represent the highest levels for each State. Several States have standards which vary by region or by season.

TABLE 63.—MONTHLY NEED AND PAYMENT STANDARD FOR AN AFDC FAMILY OF 2 AND AN AFDC FAMILY OF 4, AS OF JULY 1, 1978

State	2 Person Family			4 Person Family		
	Need	Payment	Highest Amount Paid	Need	Payment	Highest Amount Paid
Alabama	$144	$ 89	$ 89	$240	$148	$148
Alaska	350	350	350	450	450	450
Arizona	180	135	135	282	212	212
Arkansas	193	133	133	273	188	188
California	297	287	287	444	423	423
Colorado *	217	217	217	326	326	326
Connecticut	341	341	341	492	492	492
Delaware	181	181	181	287	287	287
District of Columbia	226	203	203	349	314	314
Florida	150	128	128	230	196	196
Georgia	161	105	105	227	148	148
Guam	201	201	201	306	306	306
Hawaii	390	390	390	546	546	546
Idaho	298	260	260	421	367	367
Illinois	227	227	227	333	333	333

TABLE 63.—MONTHLY NEED AND PAYMENT STANDARD FOR AN AFDC FAMILY OF 2 AND AN AFDC FAMILY OF 4, AS OF JULY 1, 1978—Continued

Indiana	247	222	175	363	327	275
Iowa	275	275	275	395	395	395
Kansas	274	274	274	364	364	364
Kentucky	135	135	135	235	235	235
Louisiana	240	101	101	410	172	172
Maine	205	185	185	349	314	314
Maryland	203	172	172	314	267	267
Massachusetts	279	279	279	396	396	396
Michigan	309	309	309	449	449	449
Minnesota	300	300	300	424	424	424
Mississippi	188	188	60	252	252	101
Missouri	250	175	175	365	256	256
Montana	167	167	167	331	331	331
Nebraska	250	250	250	370	370	370
Nevada	229	185	185	341	276	276
New Hampshire	263	263	263	346	346	346
New Jersey	247	247	247	374	374	374
New Mexico	160	160	154	239	239	229
New York	333	333	333	476	476	476
North Carolina	159	159	159	200	200	200
North Dakota	235	235	235	370	370	370
Ohio	284	192	192	431	291	291
Oklahoma	198	198	198	309	309	309
Oregon	297	271	271	441	403	403
Pennsylvania	260	260	260	373	373	373
Puerto Rico	78	78	34	126	126	54
Rhode Island *	297	297	297	418	418	418
South Carolina	144	144	78	229	229	124
South Dakota	259	259	259	340	340	340
Tennessee	142	97	97	217	148	148
Texas	115	86	86	187	140	140
Utah	316	243	243	486	374	374
Vermont	418	345	345	577	477	477
Virgin Islands	92	92	92	166	166	166
Virginia	267	240	240	372	335	335
Washington	308	308	308	439	439	439
West Virginia	219	164	164	332	249	249
Wisconsin	371	326	326	520	458	458
Wyoming	245	245	245	305	305	305

Source: AFDC Standards for Basic Needs, July 1978. HEW Publication #SSA-79-11924 ORS Reg. D-2 (778).

* Figures represent winter months.

R. INCOME LEVELS FOR THE MEDICALLY NEEDY

Table 64 shows the varying income levels established by States with medically needy programs. Persons and families meeting all other requirements for Medicaid eligibility (including resource levels, and belonging to one of the categorically related groups of aged, blind, disabled, or families with dependent children) can become eligible for medical assistance if their income falls below these levels, even though they are not receiving a cash assistance payment. For persons and

families with incomes above these levels, any medical expenses incurred can be deducted from income in determining eligibility, allowing these persons to "spend down" to Medicaid eligibility.

These levels, like the cash assistance levels, vary greatly among the States.

TABLE 64.—INCOME LEVELS FOR MEDICALLY NEEDY IN TITLE XIX PLANS IN OPERATION AS OF JULY 1978 [1]

(Annual Income)

State	Income Protected for Maintenance, By Number of Family Members				
	1	2	3	4	Plus Dollars for Additional Persons
Arkansas	$1700	$2200	$2600	$3100	5—$3500; 6—$3900; 7—$4200; 8—$4600; 9—$4900; 10—$5200; $300 for each additional person.
California	$2652	$3804	$4704	$5604	5—$6396; 6—$7200; 7—$7896; 8—$8604; 9—$9300; 10—$9996
Connecticut					
Region A	$3300	$4500	$5100	$6000	5—$6700; 6—$7500; 7—$8300; 8—$9200; 9—$9800; 10—$10,700
Region B	$3100	$4200	$4400	$5100	5—$5900; 6—$6600; 7—$7500; 8—$8300; 9—$8900; 10—$9800
Region C	$2900	$4100	$4300	$5000	5—$5700; 6—$6500; 7—$7200; 8—$8000; 9—$8700; 10—$9700
District of Columbia	$2300	$3500	$3700	$3900	5—$4352; 6—$5119; 7—$5875; 8—$6491; 9—$7139; 10—$7754.
Guam	$1500	$2500	$2800	$3000	5—$3200; 6—$3400; 7—$3600; 8—$3800; 9—$4000; 10—$4200; $200 for each additional person.
Hawaii	$3600	$4800	$5600	$6600	5—$7500; 6—$8400; 7—$9600; 8—$10,200; 9—$10,800; 10—$11,400; $600 for each additional person.
Illinois	$2100	$2600	$3100	$3800	5—$4500; 6—$5100; 7—$5800; 8—$6100; 9—$6700; 10—$7300; $576 for each additional person.
Kansas	$3400	$4000	$4400	$4900	5—$5400; 6—$5900; 7—$6200; 8—$6600; 9—$7000; 10—$7300; $360 for each additional person.
Kentucky	$1800	$2200	$3000	$3800	5—$4400; 6—$5000; 7—$5600; 8—$6200; 9—$6800; 10—$7400; $600 for each additional person.
Louisiana Urban	$1500	$1704	$2304	$2796	5—$3300; 6—$3696; 7—$4200; 8—$4596; 9—$5004; 10—$5496.
Louisiana Rural	$1296	$1500	$2100	$2604	5—$3096; 6—$3504; 7—$3996; 8—$4404; 9—$4800; 10—$5196.
Maine	$2520	$3200	$4300	$5400	5—$6400; 6—$7500; 7—$8600; 8—$9700; 9—$10,800; 10—$11,800; $1,068 for each additional person.
Maryland	$2300	$2800	$3300	$3800	5—$4300; 6—$4800; 7—$5300; 8—$5800; 9—$6300; 10—$6800; $504 for each additional person.
Massachusetts	$3600	$4500	$4680	$5280	5—$5880; 6—$6480; 7—$7080; 8—$7680; 9—$8280; 10—$9000; $720 for each additional person.
Michigan [2] (Wayne Co.)	$2598	$3468	$4200	$5040	5—$5856; 6—$6672; 7—$7428; 8—$8164; 9—$8490; 10—$9696; $756 for each additional person.
Minnesota	$2600	$3300	$3900	$4500	5—$5100: 6—$6000; 7—$6400; 8—$7000; 9—$7600; 10—$8200; $624 for each additional person.
Montana	$2004	$3444	$4008	$4572	5—$5136; 6—$5700; 7—$6264; 8—$6828; 9—$7392; 10—$7956.
Nebraska	$3100	$4000	$4800	$5600	5—$6400; 6—$7200; 7—$8000; 8—$8800; 9—$9600; 10—$10,400; $400 for each additional person.
New Hampshire	$3000	$3500	$4100	$4600	5—$5100; 6—$5700; 7—$6200; 8—$7000; 9—$7400; 10—$5200; $564 for each additional person.
New York	$3100	$4400	$4500	$5000	5—$5800; 6—$6500; 7—$7400; 8—$8096; 9—$8792; 10—$9488; $696 for each additional person.
North Carolina	$1700	$2200	$2500	$2800	5—$3000; 6—$3200; 7—$3400; 8—$3600; 9—$3800; 10—$4000; $100 for each additional person.
North Dakota	$2400	$3400	$4300	$5300	5—$6000; 6—$6600; 7—$7100; 8—$7400; 9—$7700; 10—$8000; $228 for each additional person.
Oklahoma	$2600	$3200	$4100	$5000	5—$5800; 6—$6600; 7—$7400; 8—$8000; 9—$8700; $600 for each additional person.
Pennsylvania	$2700	$4000	$4250	$4500	5—$5100; 6—$5550; 7—$6200; 8—$6850; 9—$7500; 10—$8150; $325 for each additional person.
Puerto Rico	$2500	$3200	$3800	$4400	5—$5000; 6—$5600; 7—$6200; 8—$6800; 9—$7400; 10—$8000; $600 for each additional person.

TABLE 64.—INCOME LEVELS FOR MEDICALLY NEEDY IN TITLE XIX PLANS IN OPERATION AS OF JULY 1978 [1]—Continued

Rhode Island	$3600	$4300	$5300	$6100	5—$6800; 6—$7700; 7—$8500; 8—$9300; 9—$10,000; $400 for each additional person.
Tennessee	$1404	$1600	$2000	$2400	5—$2800; 6—$3300; 7—$3700; 8—$4100; 9—$4600; 10—$5000; $264 for each additional person.
Utah	$2700	$3800	$4800	$5800	5—$7200; 6—$8400; 7—$8900; 8—$9400; 9—$9984; 10—$10,500.
Vermont	$3288	$4224	$5028	$5724	5—$6504; 6—$7008; 7—$7788; 8—$8520; 9—$9216; 10—$9912; $696 for each additional person.
Virgin Islands	$2200	$2800	$3200	$3600	5—$4100; 6—$4500; 7—$5000; 8—$5400; 9—$5800; 10—$6300; $440 for each additional person.
Virginia					
Group I	$2300	$2700	$3100	$3500	5—$3900; 6—$4300; 7—$4800; 8—$5300; 9—$5800; 10—$6400; $600 for each additional person.
Group II	$2500	$3100	$3400	$3800	5—$4200; 6—$4600; 7—$5100; 8—$5600; 9—$6100; 10—$6700; $600 for each additional person.
Group III	$2900	$3500	$3900	$4300	5—$4800; 6—$5300; 7—$5800; 8—$6400; 9—$6900; 10—$7400; $600 for each additional person.
Washington	$2772	$3948	$4500	$5268	5—$6036; 6—$6804; 7—$7572; 8—$8340; 9—$9108; 10—$9876; $64 for each additional person.
West Virginia	$2000	$2200	$2800	$3300	5—$3800; 6—$4300; 7—$4800; 8—$5400; 9—$6000; 10—$6600; $600 for each additional person.
Wisconsin	$3400	$5000	$5300	$6300	5—$7200; 6—$7800; 7—$8400; 8—$9000; 9—$9400; 10—$9600; $300 for each additional person.

[1] The following 20 States are not listed since they do not include the "medically needy" in the scope of the program: Alabama, Alaska, Colorado, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Mississippi, Missouri, Nevada, New Jersey, New Mexico, Ohio, Oregon, South Carolina, South Dakota, Texas, and Wyoming.
[2] There are five additional district scales, ranging from $2346 to $3108 for a family of one.

IV. Administrative Information and Data

The fourth section of this report (Tables 65-74) provides information on various aspects of the administration of the Medicaid program.

A. COST OF MEDICAID ADMINISTRATION

Medicaid is a program which is administered by the States under general Federal guidelines. With the exception of salaries and expenses of the Federal staff who oversee the program, and a relatively small direct Federal expenditure for support of review activities of Medicaid inpatient hospital services by Professional Standards Review Organizations (PSROs), all administrative costs of the program occur at the State and local levels.

Administrative costs are generally matched by a 50 percent Federal contribution, with the exception that the Federal government will match 90 percent of the costs of developing automated claims processing and management information systems, and 75 percent of the costs of operating such systems. In addition, the costs of professional medical personnel used in program administration are matched at a 75 percent rate, and the costs of skilled nursing facility inspectors are matched at a 100 percent rate.

The following table, Table 65, shows total expenditures for administration and training for the Medicaid program in each State for Fiscal Years 1973, 1974, 1975, 1976, and 1977.

TABLE 65.—TOTAL (FEDERAL AND STATE) COST OF STATE ADMINISTRATION AND TRAINING FOR MEDICAID BY STATE, FISCAL YEAR 1973 TO FISCAL YEAR 1977

(in thousands of dollars)

State	Fiscal year 1973	1974	1975	1976	1977
Alabama	$3,388	$4,535	$6,283	$7,127	6,850
Alaska	183	488	830	955	895
Arizona [1]	---	---	---	---	---
Arkansas	783	1,315	2,609	5,105	5,760
California	87,616	89,287	98,559	112,998	142,712
Colorado	3,865	4,357	5,673	5,670	6,439
Connecticut	4,836	4,609	5,795	6,289	7,336
Delaware	407	651	718	880	1,040
District of Columbia	4,028	4,450	4,852	7,422	7,916
Florida	3,766	6,113	9,162	9,365	12,231
Georgia	2,110	4,369	7,413	11,565	15,854
Guam	58	22	53	71	76
Hawaii	1,423	1,579	1,636	2,088	3,130
Idaho	535	578	1,239	1,717	2,490
Illinois	24,541	22,726	23,233	29,105	44,746
Indiana	5,455	5,584	11,254	12,236	14,109
Iowa	1,951	3,636	5,058	6,647	6,654
Kansas	2,568	3,851	5,180	6,332	6,914
Kentucky	4,077	3,985	6,150	8,775	10,578
Louisiana	1,592	2,835	4,502	5,776	8,851
Maine	1,352	1,480	2,098	2,569	2,875
Maryland	8,590	9,389	11,772	12,191	13,523
Massachusetts	11,227	16,921	26,095	27,836	27,279
Michigan	18,674	22,788	46,567	58,172	73,987
Minnesota	5,341	7,139	12,023	14,285	19,544
Mississippi	2,379	4,614	6,689	7,472	7,781
Missouri	1,685	2,207	3,015	4,970	7,191
Montana	842	1,266	1,787	2,211	2,990
Nebraska	1,272	3,076	5,687	7,289	6,430
Nevada	862	1,309	1,779	2,323	2,590
New Hampshire	1,122	1,519	2,488	2,306	3,418
New Jersey	11,171	12,502	15,727	18,675	21,992
New Mexico	1,953	2,013	1,688	2,733	3,219
New York	97,537	78,928	70,138	80,241	179,801
North Carolina	5,238	6,586	9,295	10,348	17,087
North Dakota	610	957	1,372	1,592	2,072
Ohio	4,458	11,609	23,298	25,216	30,599
Oklahoma	4,181	5,393	9,960	13,810	16,839
Oregon	2,922	4,381	6,282	6,939	9,423
Pennsylvania	14,863	15,829	19,919	24,129	34,671
Puerto Rico	4,173	5,057	5,625	4,740	5,269
Rhode Island	1,568	2,032	2,840	3,075	3,882
South Carolina	1,400	1,727	3,501	6,570	8,193
South Dakota	643	1,137	2,243	1,560	1,954
Tennessee	3,016	3,757	5,602	6,735	7,572
Texas	6,385	17,202	17,557	36,825	59,090
Utah	771	1,846	4,057	3,691	3,772
Vermont	1,120	1,378	1,871	1,902	3,262
Virgin Islands	402	274	198	268	373
Virginia	6,089	7,843	9,109	10,146	10,289
Washington	3,746	7,445	8,747	11,335	15,028
West Virginia	1,850	1,293	2,940	3,820	4,626
Wisconsin	10,517	7,386	6,863	7,763	10,610
Wyoming	161	261	351	564	615
Total	$391,302	$433,512	$549,377	$664,426	$922,455

[1] No Medicaid program.

Source: State expenditures for public assistance programs approved under Titles I, IV-A, X, XIV, XVI, and XIX of the Social Security Act.

B. FEDERAL STAFF IN THE MEDICAID PROGRAM

The Federal unit responsible for overseeing the Medicaid program is the Health Care Financing Administration.

Federal employees have no direct responsibility for the operation of individual Medicaid programs, which are administered at the State (and local) level. They are responsible, however, for oversight of the State administration of the program.

The number of Federal staff directly involved in Medicaid from 1970 to 1979 is shown in Table 66. The increase in regional staff between 1977 and 1978 is to a large extent the result of the reorganization of HEW. During the reorganization, staff functions formerly at the SRS level (Financial Management and Special Initiatives) were assigned to the Medicaid Bureau regional staff.

TABLE 66.—FEDERAL PERSONNEL EMPLOYED IN THE MEDICAID PROGRAM, 1970-1979

	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979
Central Office	168	167	167	182	127	125	172	252	315	343
Regional Offices	59	59	134	120	97	136	172	190	393	496
Total	227	226	301	302	224	261	344	442	708	839

Source: HCFA.

C. STATE AGENCY RESPONSIBLE FOR ADMINISTRATION OF MEDICAID

Federal law requires that one State agency must be designated as the single State agency responsible for the administration of the Medicaid program. Traditionally, that agency has been either the State welfare agency, the State health agency, or the umbrella human resources agency. Tables 67 and 68 provide information on the agencies in each State which administer the Medicaid program.

TABLE 67.—TYPE OF AGENCY ADMINISTERING MEDICAID BY STATE

State	Health	Welfare	Umbrella	Other
Alabama [1]				X
Alaska			X	
Arizona [2]				
Arkansas			X	
California	X			
Colorado		X		
Connecticut		X		
Delaware			X	
District of Columbia			X	
Florida			X	
Georgia [3]				X
Guam			X	
Hawaii		X		
Idaho			X	
Illinois		X		
Indiana		X		
Iowa		X		
Kansas			X	
Kentucky			X	
Louisiana			X	
Maine			X	
Maryland	X			
Massachusetts		X		
Michigan		X		
Minnesota		X		
Mississippi [4]				X
Missouri			X	
Montana		X		
Nebraska		X		
Nevada			X	
New Hampshire			X	
New Jersey [5]				X
New Mexico			X	
New York		X		
North Carolina			X	
North Dakota		X		
Ohio		X		
Oklahoma			X	
Oregon			X	
Pennsylvania		X		
Puerto Rico	X			
Rhode Island			X	
South Carolina		X		
South Dakota		X		
Tennessee	X			
Texas		X		
Utah		X		
Vermont		X		
Virgin Islands	X			
Virginia	X			
Washington	X			
West Virginia		X		
Wisconsin			X	
Wyoming			X	

[1] Office of the Governor.
[2] No Medicaid program.
[3] Independent agency.
[4] Independent commission for Medicaid.
[5] Department of Human Services.
Source: Public Welfare Directory, 1978-1979.

Table 68.—MEDICAID DIRECTORY

Single State Agencies and State Medical Assistance Units

Alabama (region IV):
Single State agency and Medical assistance unit:
Medical Services Administration
2500 Fairlane Drive
Montgomery, Alabama 36130
205/277-2710

Alaska (region X):
Single State agency:
Department of Health and Social Services
Pouch H-01
Juneau, Alaska 99811
907/465-3030
Medical assistance unit:
Division of Public Assistance
Department of Health and Social Services
Pouch H-07
Juneau, Alaska 99811
907/465-3355

Arkansas (region VI):
Single State agency:
Department of Human Services
406 National Old Line Building
Little Rock, Arkansas 72201
501/371-1001
Medical assistance unit:
Office of Medical Services
Division of Social Services
Department of Human Services
P.O. Box 1437
Little Rock, Arkansas 72203
501/371-1806

California (region IX):
Single State agency:
Department of Health Services
714 P Street—Room 1253
Sacramento, California 95814
916/445-1248
Medical assistance unit:
Assistant Director
State Dept. of Health Services
714 P Street
Sacramento, California 95814
916/445-1351

Colorado (region VIII):
Single State agency:
Department of Social Services
1575 Sherman Street
Denver, Colorado 80203
303/839-3041
Medical assistance unit:
Division of Medical Assistance
Department of Social Services
1575 Sherman Street
Denver, Colorado 80203
303/839-3031

Connecticut (region I):
Single State agency:
Dept. of Income Maintenance
110 Bartholomew Avenue
Hartford, Connecticut 06106
203/566-2008
Medical assistance unit:
Medical Care Administration
Dept. of Income Maintenance
110 Bartholomew Avenue
Hartford, Connecticut 06106
203/566-4120

Delaware (region III):
Single State agency:
Department of Health and Social Services
Delaware State Hospital
New Castle, Delaware 19720
302/421-6705
Medical assistance unit:
Medical Assistance Services
Department of Health and Social Services
Wilmington, Delaware 19720
302/421-6361

District of Columbia (region III):
Single State agency:
Department of Human Resources
District Building—Room 406
1350 E Street, NW
Washington, D.C. 20004
202/629-3079
Medical assistance unit:
Medical Services Division
614 H Street, NW—Room 708
Washington, D.C. 20001
202/727-0735

Florida (region IV):
Single State agency:
Department of Health and Rehabilitative Services
1323 Winewood Boulevard
Tallahassee, Florida 32301
904/488-7721
Medical assistance unit:
Social & Economic Services
Department of Health and Rehabilitative Services
1323 Winewood Boulevard
Tallahassee, Florida 32301
904/488-5461

Georgia (region IV):
Single State agency:
Georgia Department of Medical Assistance
1010 West Peachtree St., NW
Atlanta, Georgia 30309
404/894-4911
Medical assistance unit:
Department of Medical Assistance
1010 West Peachtree Street, NW
Atlanta, Georgia 30309
404/894-4911

Table 68.—MEDICAID DIRECTORY—Continued

Single State Agencies and State Medical Assistance Units

Guam (region IX):
Single State agency:
Department of Public Health and Social Services
P.O. Box 2816
Agana, Guam 96910
Overseas Operator: 734-9901
Medical assistance unit:
Medical Care Service
Department of Public Health and Social Services
P.O. Box 2719
Agana, Guam 96910
Overseas Operator: 734-9901

Hawaii (region IX):
Single State agency:
Department of Social Services and Housing
P.O. Box 339
Honolulu, Hawaii 96809
808/548-6260
Medical assistance unit:
Medical Care Administration
Department of Social Services and Housing
P.O. Box 339
Honolulu, Hawaii 96809
808/548-6584

Idaho (region X):
Single State agency:
Department of Health and Welfare
Statehouse
Boise, Idaho 83720
208/384-2336
Medical assistance unit:
Bureau of Medical Assistance
Department of Health and Welfare
Statehouse
Boise, Idaho 83720
208/384-3556

Illinois (region V):
Single State agency:
Illinois Dept. of Public Aid
316 South Second Street
Springfield, Illinois 62762
217/782-6716
Medical assistance unit:
Division of Medical Program Services
931 E. Washington Street
Springfield, Illinois 62763
217/782-0506

Indiana (region V):
Single State agency:
Indiana Dept. of Public Welfare
State Office Building
100 North Senate Avenue—Room 701
Indianapolis, Indiana 46204
317/633-6650
Medical assistance unit:
Assistant Administrator—Medicaid
State Dept. of Public Welfare
100 North Senate Avenue
Room 701
Indianapolis, Indiana 46204
317/633-5582

Iowa (region VII):
Single State agency:
Department of Social Services
Hoover State Office Building
Des Moines, Iowa 50319
515/281-5452
Medical assistance unit:
Medical Services Section
Department of Social Services
Hoover State Office Bldg.—5th Fl.
Des Moines, Iowa 50319
515/281-5452

Kansas (region VII):
Single State agency:
Department of Social and Rehabilitation Service
State Office Building
Topeka, Kansas 66612
913/296-3271
Medical assistance unit:
Medical Services Section
Department of Social and Rehabilitation Service
State Office Building
Topeka, Kansas 66612
913/296-3981

Kentucky (region IV):
Single State agency:
Department of Human Resources
DHR Building
Frankfort, Kentucky 40601
502/564-7130
Medical assistance unit:
Division for Medical Assistance
Department of Human Resources
Frankfort, Kentucky 40601
502/564-4321

Louisiana (region VI):
Single State agency:
Louisiana Health and Human Resources Administration
P.O. Box 3776
Baton Rouge, Louisiana 70821
504/389-7611
Medical assistance unit:
Medical Assistance Program Administration
Office of Family Security
P.O. Box 44065
Baton Rouge, Louisiana 70804
504/389-3870

Table 68.—MEDICAID DIRECTORY—Continued

Single State Agencies and State Medical Assistance Units

Maine (region I):
Single State agency:
Department of Human Services
Statehouse
Augusta, Maine 04333
207/289-2736
Medical assistance unit:
Bureau of Medical Services
Department of Human Services
Statehouse
Augusta, Maine 04333
207/289-3846

Maryland (region III):
Single State agency:
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201
301/383-2600
Medical assistance unit:
Medical Programs
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201
301/383-6327

Massachusetts (region I):
Single State agency:
Department of Public Welfare
600 Washington Street
Boston, Massachusetts 02111
617/727-6190
Massachusetts Commission for the Blind
110 Tremont Street
Boston, Massachusetts 02108
617/727-5580
Medical assistance unit:
Medical Assistance
Department of Public Welfare
600 Washington Street
Boston, Massachusetts 02111
617/727-6095/3907
Medical Assistance
Massachusetts Commission for the Blind
110 Tremont Street
Boston, Massachusetts 02108
617/727-5590

Michigan (region V):
Single State agency:
Michigan Department of Social Services
Commerce Center Building
300 South Capitol Avenue
Lansing, Michigan 48926
517/373-2000
Medical assistance unit:
Medical Services Administration
Department of Social Services
300 South Capitol Avenue
Lansing, Michigan 48926
517/373-1970

Minnesota (region V):
Single State agency:
Department of Public Welfare
Centennial Office Building
658 Cedar Street
Saint Paul, Minnesota 55155
612/296-2701
Medical assistance unit:
Medical Assistance Program
Bureau of Income Maintenance
Department of Public Welfare
690 North Robert Street—
P.O. Box 43170
Saint Paul, Minnesota 55164
612/296-8517

Mississippi (region IV):
Single State agency and Medical assistance unit:
Mississippi Medicaid Commission
4785 I-55 North
P.O. Box 16786
Jackson, Mississippi 39206
601/354-7464

Missouri (region VII):
Single State agency:
Department of Social Services
Broadway State Office Building
Jefferson City, Missouri 65101
314/751-4815
Medical assistance unit:
Division of Family Services
Department of Social Services
Broadway State Office Building
Jefferson City, Missouri 65101
314/751-2500

Montana (region VIII):
Single State agency:
Department of Social and Rehabilitation Services
P.O. Box 4210
Helena, Montana 59601
406/449-5622
Medical assistance unit:
Medical Assistance Bureau
Economic Assistance Division
Department of Social and Rehabilitation Services
P.O. Box 4210
Helena, Montana 59601
406/449-3952

Nebraska (region VII):
Single State agency:
Department of Public Welfare
301 Centennial Mall South
5th Floor
Lincoln, Nebraska 68509
402/471-3121

Table 68.—MEDICAID DIRECTORY—Continued

Single State Agencies and State Medical Assistance Units

Medical assistance unit:
Medical Services Division
Department of Public Welfare
301 Centennial Mall South
5th Floor
Lincoln, Nebraska 68509
402/471-3121

Nevada (region IX):
Single State agency:
Department of Human Resources
Kinkead Building Capitol Complex
505 East King Street
Carson City, Nevada 89710
702/885-4730

Medical assistance unit:
Medical Care Section (Title XIX)
Welfare Division
Department of Human Resources
251 Jeanell Drive
Capitol Complex
Carson City, Nevada 89710
702/885-4775

New Hampshire (region I):
Single State agency:
Department of Health and Welfare Services
Hazen Drive
Concord, New Hampshire 03301
603/271-4331

Medical assistance unit:
Office of Medical Services
Hazen Drive
Concord, New Hampshire 03301
603/271-3706

New Jersey (region II):
Single State agency:
Department of Human Services
Capitol Place 1
Trenton, New Jersey 08625
609/292-3717

Medical assistance unit:
Division of Medical Assistance and Health Services
Department of Human Services
324 East State Street
Trenton, New Jersey 08625
609/292-7244

New Mexico (region VI):
Single State agency:
Department of Human Services
P.O. Box 2348
Sante Fe, New Mexico 87503
505/827-2371

Medical assistance unit:
Medical Assistance Bureau
Department of Human Services
P.O. Box 2348
Sante Fe, New Mexico 87503
505/827-5551

New York (region II):
Single State agency:
State Dept. of Social Services
Ten Eyck Office Building
40 North Pearl Street
Albany, New York 12243
518/474-9475

Medical assistance unit:
Division of Medical Assistance
State Dept. of Social Services
Ten Eyck Office Building
40 North Pearl Street
Albany, New York 12243
518/474-9132

North Carolina (region IV):
Single State agency:
Department of Human Resources
325 N. Salisbury Street
Raleigh, North Carolina 27611
919/733-4534

Medical assistance unit:
Division of Medical Assistance
Department of Human Resources
336 Fayetteville Street Mall
Raleigh, North Carolina 27601
919/733-2060

North Dakota (region VIII):
Single State agency:
Social Service Board of North Dakota
State Capitol Building
Bismarck, North Dakota 58505
701/224-2310

Medical assistance unit:
Medical Service
Social Service Board of North Dakota
State Capitol Building
Bismarck, North Dakota 58505
701/224-2321

Ohio (region V):
Single State agency:
Department of Public Welfare
30 East Broad Street, 32nd floor
Columbus, Ohio 43215
614/466-6282

Medical assistance unit:
Division of Medical Assistance
Department of Public Welfare
30 East Broad Street, 31st floor
Columbus, Ohio 43215
614/466-2365

Oklahoma (region VI):
Single State agency:
Department of Institutions
Social and Rehabilitative Services
P.O. Box 25352
Oklahoma City, Oklahoma 73125
405/521-3646

Table 68.—MEDICAID DIRECTORY—Continued

Single State Agencies and State Medical Assistance Units

Medical assistance unit:
Medical Units
Department of Institutions
Social and Rehabilitative Services
P.O. Box 25352
Oklahoma City, Oklahoma 73125
405/521-3801

Oregon (region X):
Single State agency:
Department of Human Resources
318 Public Service Building
Salem, Oregon 97310
503/378-3034
Medical assistance unit:
Adult and Family Services Division
Department of Human Resources
203 Public Service Building
Salem, Oregon 97310
503/378-2263

Pennsylvania (region III):
Single State agency:
State Department of Public Welfare
Health and Welfare Building
Harrisburg, Pennsylvania 17120
717/787-2600/3600
Medical assistance unit:
Bureau of Medical Assistance
State Department of Public Welfare
7th and Forester Streets
Harrisburg, Pennsylvania 17120
717/787-1174

Puerto Rico (region II):
Single State agency:
Department of Health
P.O. Box 9342
Santurce, Puerto Rico 00908
809/751-8259
Medical assistance unit:
Health Economy Office
Department of Health
P.O. Box 10037
Caparra Heights Station
Rio Piedras, Puerto Rico 00922
809/765-9941

Rhode Island (region I):
Single State agency:
Department of Social and Rehabilitative Services
Aime J. Forand Building
600 New London Avenue
Cranston, Rhode Island 02920
401/464-2121
Medical assistance unit:
Division of Medicaid Services
Department of Social and Rehabilitative Services
Aime J. Forand Building
600 New London Avenue
Cranston, Rhode Island 02920
401/464-2174

South Carolina (region IV):
Single State agency:
State Department of Social Services
P.O. Box 1520
Columbia, South Carolina 29202
803/758-3244
Medical assistance unit:
Health Care Financing
State Department of Social Services
P.O. Box 1520
Columbia, South Carolina 29202
803/758-8182

South Dakota (region VIII):
Single State agency:
Department of Social Services
Kneip Building
Pierre, South Dakota 57501
605/773-3165
Medical assistance unit:
Office of Medical Services
Department of Social Services
State Office Building III
Pierre, South Dakota 57501
605/224-3495

Tennessee (region IV):
Single State agency:
Department of Public Health
344 Cordell Hull Building
Nashville, Tennessee 37219
615/741-3111
Medical assistance unit:
Bureau of Medicaid Administration and Coordination
Department of Public Health
283 Plus Park Boulevard
Nashville, Tennessee 37219
615/741-6345

Texas (region VI):
Single State agency:
Department of Human Resources
John H. Reagan Building
Austin, Texas 78701
512/475-5777
Medical assistance unit:
Deputy Commissioner for Medical Programs
John H. Reagan Building
Austin, Texas 78701
512/475-3542

Utah (region VIII):
Single State agency:
Department of Social Services
150 West North Temple
Salt Lake City, Utah 84103
801/533-5331

Table 68.—MEDICAID DIRECTORY—Continued

Single State Agencies and State Medical Assistance Units

Medical assistance unit:
Office of Health Care Financing
Department of Social Services
150 West North Temple
Salt Lake City, Utah 84103
801/533-5038

Vermont (region I):
Single State agency:
Agency of Human Services
State Office Building
Four East State Street
Montpelier, Vermont 05602
802/241-2220
Medical assistance unit:
Division of Medical Care
Department of Social Welfare
State Office Building
Montpelier, Vermont 05602
802/241-2880

Virgin Islands (region II):
Single State agency:
Department of Health
Charlotte Amalie
St. Thomas, Virgin Islands 00801
809/774-0117
Medical assistance unit:
Bureau of Health Insurance and Medical Assistance
Department of Health
Franklin Building
Charlotte Amalie
St. Thomas, Virgin Islands 00801
809/774-4624

Virginia (region III):
Single State agency:
State Department of Health
109 Governor Street
Richmond, Virginia 23219
804/786-3561
Medical assistance unit:
Medical Assistance Program
State Department of Health
109 Governor Street
Richmond, Virginia 23219
804/786-7933

Washington (region X):
Single State agency:
Health Services Division
Department of Social and Health Services
Mail Stop OB 44J
Olympia, Washington 98504
206/753-5871
Medical assistance unit:
Office of Medical Assistance
Department of Social and Health Services
Mail Stop LK-11
Olympia, Washington 98504
206/753-5839

West Virginia (region III):
Single State agency:
Office of Assistant Commissioner of Medical Services
1900 Washington Street, East
Charleston, West Virginia 25305
304/348-2400
Medical assistance unit:
Division of Medical Care
Department of Welfare
1900 Washington Street, East
Charleston, West Virginia 25305
304/348-8900

Wisconsin (region V):
Single State agency:
Department of Health and Social Services
One West Wilson Street—Rm. 663
Madison, Wisconsin 53702
608/266-3681
Medical assistance unit:
Bureau of Health Financing
Division of Health
Department of Health and Social Services
One West Wilson Street—Rm. 325
Madison, Wisconsin 53702
608/266-2522

Wyoming (region VIII):
Single State agency:
Department of Health and Social Services
317 Hathaway Building
Cheyenne, Wyoming 82002
307/777-7657
Medical assistance unit:
Medical Assistance Services
Division of Health and Social Services
Department of Health and Social Services
417 Hathaway Building
Cheyenne, Wyoming 82002
307/777-7533

Although the single State agency bears ultimate responsibility for administration of the Medicaid program, that agency often contracts with other State agencies for carrying out some of the functions necessary to the program. For example, the State health agency is responsible for surveying and certifying health facilities, even though it may not be designated as the single State agency. The State welfare agency normally carries out the function of determining Medicaid eligibility for families and medically needy persons.

Since the implementation of the Federal welfare program for aged, blind and disabled persons (the Supplemental Security Income program, known as SSI), States may also contract with the Social Security Administration, which administers SSI, to determine Medicaid eligibility for persons receiving a Federal SSI payment or a Federally-administered supplementary payment. (A State may contract with Social Security only if they provide Medicaid to all SSI recipients; if they have exercised their option to retain any aspect of their Medicaid standard in effect prior to the implementation of SSI, they must perform their own eligibility determinations.) Table 69 indicates whether this function is carried out by the Federal agency or by the State.

TABLE 69.—ARRANGEMENTS FOR DETERMINING MEDICAID ELIGIBILITY FOR PERSONS RECEIVING SSI OR A MANDATORY SUPPLEMENT, BY STATE, JANUARY, 1979

State	Level at which Medicaid eligibility for SSI recipients is determined	Level at which Medicaid eligibility for recipients of mandatory supplement is determined
Alabama	Federal	Federal
Alaska	State	State
Arizona	(1)	(1)
Arkansas	Federal	Federal
California	Federal	Federal
Colorado	State	State
Connecticut	State [2]	State
Delaware	Federal	Federal
District of Columbia	Federal	Federal
Florida	Federal	Federal
Georgia	Federal	Federal
Hawaii	State [2]	State
Idaho	State	State
Illinois	State [2]	State
Indiana	State [2]	State
Iowa	Federal	Federal
Kansas	State	State
Kentucky	Federal	Federal
Louisiana	Federal	Federal
Maine	Federal	Federal
Maryland	Federal	Federal
Massachusetts	Federal	Federal
Michigan	Federal	Federal
Minnesota	State [2]	State
Mississippi	State [2]	State
Missouri	State [2]	State
Montana	Federal	Federal
Nebraska	State [2]	State
Nevada	State	State
New Hampshire	State [2]	State
New Jersey	Federal	Federal
New Mexico	Federal	Federal
New York	Federal	Federal
North Carolina	State [2]	State
North Dakota	State	State
Ohio	State [2]	State
Oklahoma	State [2]	State
Oregon	State	State
Pennsylvania	Federal	Federal
Rhode Island	Federal	Federal
South Carolina	Federal	Federal
South Dakota	Federal	Federal
Tennessee	Federal	Federal
Texas	Federal	(3)
Utah	State [2]	State
Vermont	Federal	Federal
Virginia	State [2]	State
Washington	Federal	State
West Virginia	Federal	Federal
Wisconsin	Federal	Federal
Wyoming	Federal	Federal
Totals	Federal-29	Federal-27
	State-21	State-22

[1] No Medicaid program.

[2] Has retained at least some aspect of its pre-SSI eligibility standard, so is not able to contract with the Federal agency for eligibility determinations.

[3] No mandatory supplement.

Source: DHEW, HCFA.

Table 70.—CLAIMS PROCESSING CONTRACTS, BY TYPE OF SERVICE BY FISCAL AGENTS AND HEALTH INSURING AGENTS

KEY: [X] All Claims processed by Agent

[10] Number is percent of claims processed by Agent. Remainder are processed by State.

State	Services Covered: Inpatient Hospital Care	Physicians' Services	Dental Services	Prescribed Drugs	Skilled Nursing Facilities	Intermediate Care Facilities	Notes
Alabama	X	X	X	X	X	X	
Alaska			X				EPSDT Only
Arizona							
Arkansas	X	X	X	X			
California	X	X	X	X	X	X	
Colorado	X	X	X				
Connecticut				X			
Delaware	X	X	X	X	X	X	
District of Columbia							
Florida	X	X	X	X	X	X	Fiscal Agents handle Medicare Parts A & B deduct. & coinsurance
Georgia							
Guam							
Hawaii	X	X	X	X	X	X	
Idaho	X	X	X	X	X	X	EPSDT Only
Illinois	10						Fiscal Agent handles Medicare part A only
Indiana	X	X	X	X	X	X	
Iowa	X	X	X	X	X		
Kansas	X	X	X	X			Fiscal Agent handles Medicare SNF crossover claims
Kentucky							
Louisiana	X	X	X	X	X	X	
Maine				X			
Maryland							
Massachusetts	20	20	X	X			Fiscal Agent handles Medicare Part A and B
Michigan							
Minnesota							
Mississippi	X	X	X	X	X	X	
Missouri							
Montana	X	X	X	X	X	X	
Nebraska							
Nevada	X	X	X	X	X	X	
New Hampshire							
New Jersey	X	X	X				
New Mexico	X	X	X	X	X	X	
New York	X	X	X	X	X	X	N.Y. City only
North Carolina	X	X	X	X	X	X	
North Dakota	10	10					
Ohio							
Oklahoma							
Oregon							
Pennsylvania	X	X		X			
Puerto Rico							
Rhode Island							
South Carolina		X	X				
South Dakota	X						
Tennessee	X	X	X	X	X	X	
Texas	X	X				X	
Utah			X				
Vermont	X	X	X	X			
Virgin Islands							
Virginia	X	X	X	X	X	X	
Washington	X	X	X	X	X	X	
West Virginia							
Wisconsin	X	X	X	X	X	X	
Wyoming			X				

Prepared by: HCFA, 1-1-79

D. CLAIMS PROCESSING FOR SPECIFIED MEDICAID SERVICES

States may process claims for reimbursement themselves or contract with fiscal agents or health insuring agencies to process those claims.. Table 70 breaks out claims processing for selected services in each State according to whether the State processes the claim or contracts with a fiscal agent or health insuring agent to process claims for that service. More detailed information follows in Table 71.

TABLE 71.—FISCAL AGENTS AND HEALTH INSURING AGENCIES IN THE MEDICAID PROGRAM, JANUARY 1979

State	Name of Fiscal Agent(s) or Health Insuring Agency	Types of Claims Handled
Alabama	Blue Cross/Blue Shield of Alabama	All services.
Alaska	Delta Dental Plan of Alaska Incorporated	Dental (EPSDT only).
Arizona	(No Medicaid Program)	
Arkansas	Arkansas Blue Cross/Blue Shield	All services except SNFs and ICFs.
California	Medi-Cal Intermediary Operations (MIO):	
	Blue Cross North ***	All institutional claims for Northern California except for 3 counties.
	Blue Cross South ***	All institutional claims for Southern California.
	Blue Shield ***	All non-institutional claims except dental.
	Redwood Health Foundation **	All services except dental for the 3 northern counties of Lake, Sonoma and Mendocino.
	California Dental Service Association **	Dental.
Colorado	Computer Science Corporation	(All services to be phased in).
	Colorado Medical Service, Incorporated (Blue Cross/Blue Shield)	All services except drugs.
Connecticut	Pilgrim Health Applications, Inc.	Pharmaceutical.
Delaware	The Computer Company	All services.
District of Columbia	No Fiscal Agent	
Florida	Systems Development Corporation Integrated Services, Incorporated	All services including payment of Parts A and B deductible and coinsurance.
Georgia	No Fiscal Agent	
Guam	No Fiscal Agent	
Hawaii	Hawaii Medical Services Association (Blue Cross/Blue Shield)	All services.
Idaho	Electronic Data Systems Federal Corporation	All services.
Illinois	Blue Cross/Blue Shield	Crossover claims for Medicare Part A (Inpatient hospital services only).
Indiana	Blue Cross/Blue Shield of Indiana	All services.
Iowa	Blue Cross/Blue Shield of Iowa	All services except ICFs.
Kansas	Electronic Data Systems Federal Corporation	All services except ICFs and SNFs; also handles Medicare SNF crossover claims.
Kentucky	No Fiscal Agent	
Louisiana	Electronic Data Systems Federal Corporation	All services.
Maine	Health Systems Institute	Drugs.
Maryland	No Fiscal Agent	
Massachusetts	Blue Cross/Blue Shield of Massachusetts	Crossover claims for Medicare Part A (Inpatient hospital services only).
	Pilgrim Health Applications, Incorporated	Medicaid claims.
Michigan	No Fiscal Agent	
Minnesota	No Fiscal Agent	
Mississippi	Blue Cross/Blue Shield of Mississippi, Incorporated	All services.
Missouri	No Fiscal Agent	
Montana	Dikewood Corporation	All services.
Nebraska	No Fiscal Agent	
Nevada	Nevada Blue Shield	All services.
New Hampshire	No Fiscal Agent	
New Jersey	Hospital Service Plan of New Jersey	

TABLE 71.—FISCAL AGENTS AND HEALTH INSURING AGENCIES IN THE MEDICAID PROGRAM, JANUARY 1979—Continued

State	Name of Fiscal Agent(s) or Health Insuring Agency	Types of Claims Handled
	(New Jersey Blue Cross)	Inpatient and outpatient hospital,** and drugs.
	Prudential Insurance Company of America	All services, including some hospital,** except drugs, SNFs, ICFs, and institutions for tuberculosis and mental disease.
New Mexico	Electronic Data Systems Federal Corporation	All services.
New York	The Bradford National Corporation (New York City only)	All services.
North Carolina	Electronic Data Systems Federal Corporation	All services.
	The Computer Company (T.C.C.)	Drugs.
North Dakota	Blue Cross/Blue Shield of North Dakota *	Crossover claims for Medicare Parts A and B services for recipients 65 and over.
Ohio	No Fiscal Agent	
Oklahoma	No Fiscal Agent	
Oregon	No Fiscal Agent	
Pennsylvania	Capital Blue Cross	All pharmaceutical, medical supplies, equipment, and prosthetic devices.
	Inter-County Hospitalization Plan, Inc.	Inpatient hospital claims for Philadelphia area (Blair, Chester, and Montgomery Counties, etc.).
	Pennsylvania Blue Cross	Other inpatient hospital claims.
	Blue Shield	Physicians' inpatient care (medical and surgical) and emergency room services.
Puerto Rico	No Fiscal Agent	
Rhode Island	No Fiscal Agent	
South Carolina	Blue Cross/Blue Shield of South Carolina	All services except inpatient and outpatient hospital, drugs, SNFs and ICFs.
South Dakota	Associate Hospital Services (Blue Cross)	Inpatient hospital and home health.
Tennessee	Electronic Data Systems Federal Corporation	All services including payment of Parts A and B co-insurance and deductible.
Texas	National Heritage Insurance Company *	All services except drugs, dental, hearing aids, and SNFs.
Utah	Delta Dental Corporation	Dental.
Vermont	New Hampshire/Vermont Hospitalization Service (Blue Cross/Blue Shield)	All services except SNFs and ICFs.
Virgin Islands	No Fiscal Agent	
Virginia	The Computer Company (T.C.C.)	All services.
Washington	Electronic Data Systems Federal Corporation	All services except service in State mental institution.
West Virginia	No Fiscal Agent	
Wisconsin	Electronic Data Systems Federal Corporation	All services.
Wyoming	Wyoming Dental Services Incorporated *	Dental (EPSDT only).

* Health Insuring Agency.

** Hospitals may contract to send their claims to either fiscal agent.

*** All functions to be phased out and implemented by CSC (Computer Science Corporation).

E. MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

Development of adequate claims processing and data systems is necessary for efficient and effective management of the Medicaid program. The Social Security Amendments of 1972 authorized 90 percent Federal matching to States for the costs of design, development, and installation of mechanized claims processing and information retrieval systems, and 75 percent for the costs of operating such systems.

The Medicaid Management Information System (MMIS) is a mechanized claims processing and information retrieval system developed by HEW for use by the States as a model in developing their own systems.

Table 72 summarizes current State progress in developing and implementing adequate claims processing and management information systems.

TABLE 72.—STATUS OF STATE MEDICAID MANAGEMENT INFORMATION SYSTEM EFFORTS, APRIL 1979

State	MMIS certified	Actively planning or implementing MMIS [2]	No MMIS development
Total	25	21	8
Alabama	X		
Alaska			X
Arizona [3]			
Arkansas	X		
California	X		
Colorado		X	
Connecticut		X	
Delaware			X
District of Columbia		X	
Florida		X	
Georgia	X		
Guam			X
Hawaii	X		
Idaho	X		
Illinois		X	
Indiana	X		
Iowa		X	
Kansas	X		
Kentucky		X	
Louisiana	X		
Maine		X	
Maryland		X	
Massachusetts		X	
Michigan	X		
Minnesota	X		
Mississippi		X	
Missouri		X	
Montana	X		
Nebraska	X		
Nevada		X	

TABLE 72.—STATUS OF STATE MEDICAID MANAGEMENT INFORMATION SYSTEM EFFORTS, APRIL, 1979—Continued

New Hampshire	X		
New Jersey		X	
New Mexico	X		
New York	X [4]	X [5]	
North Carolina	X		
North Dakota		X	
Ohio	X		
Oklahoma	X		
Oregon			X
Pennsylvania		X	
Puerto Rico			X
Rhode Island			X
South Carolina		X	
South Dakota		X	
Tennessee		X	
Texas	X		
Utah	X		
Vermont	X		
Virgin Islands	X		
Virginia	X		
Washington	X		
West Virginia	X		
Wisconsin	X		
Wyoming			X

[1] "Certified" means the system has been approved by HEW to receive higher matching rate of 75 percent allowed by law.

[2] "Actively planning or implementing" is a category that covers States in a wide range of stages in the MMIS implementation process, from the stage of submitting an initial Advanced Planning Document up to the point where a State is ready to be certified as having a fully operational system.

[3] No Medicaid program.

[4] Provider group A (physicians and clinics) in New York City only is certified.

[5] Balance of New York City and State.

Source: HEW/HCFA.

F. EFFORTS TO COMBAT FRAUD AND ABUSE

The Office of Program Integrity was created in March 1977, as a component of the Health Care Financing Administration, by merging the Office of Program Review in the old Bureau of Health Insurance (Medicare) and the Division of Fraud and Abuse Control in the old Medical Services Administration (Medicaid). For years the Congress and the Administration had sought to assure coordination and exchange of information between Medicare and Medicaid on suspect individual health providers and techniques for fraud and abuse control. Now that a single staff is addressing problems of fraud and abuse control in both Medicare and Medicaid, there is a greater opportunity than ever before to foster uniform approaches and assume coordination between the two programs.

The Medicaid related activities aimed at these goals include the assessment of State Medicaid agencies' efforts to deter, detect, investi-

gate, and prosecute Medicaid fraud cases, assistance in investigation and prosecution, the design of detection systems, and the development of overall management systems to prevent fraud. The States' capabilities to prevent and detect fraud and abuse will now be substantially increased as a result of Public Law 95-142 which was enacted in October 1977. This legislation authorizes Federal funding to enable the States to create State Medicaid Fraud Control Units to support the investigation and prosecution of fraud in State Medicaid programs.

Tables 73 and 74 summarize information reported by States on their anti-fraud and abuse efforts.

TABLE 73.—12 MONTH SUMMARY OF REPORTED FRAUD AND ABUSE ACTIVITY

	Quarter Ending			
	March 1977	June 1977	September 1977	December 1977
Cases Pending at Start of Quarter	10,820	9968	9985	9952
Cases Added During Period	910	1130	1146	1062
Cases Disposed of	1840	1119	700	601
Referred to Law Enforcement Officials	121	113	89	57
Not Referred to Law Enforcement Officals	1719	1006	611	544
Cases Pending End of Quarter	9890	9979	8839	8890
Investigation Not Begun	980	357	375	352
Investigation Underway but Incomplete	8910	9622	7464	8538

Source: HCFA/OPPR, State Fraud and Abuse Reporting Form, Reporting Date May 17, 1979.

TABLE 74.—SUMMARY OF FRAUD DETECTION AND PROSECUTION, FY 1976 AND FY 1977

(In thousands of dollars)

	TOTAL	
	Fiscal Year 1976	Fiscal Year 1977
Number of Complete Investigations Begun	3383	4034
Number of Cases Closed:		
Referral to Law Enforcement Officials	269	387
Without Referral to Law Enforcement Officials	2372	4106
Law Enforcement Actions Completed	126	164
Number of Convictions	56	89
Total Dollars Recovered from Administrative Actions [1]	$1269.7	$ 401.4
Total Dollars Recovered from Prosecution [1]	350.3	627.2
Total	$1620.0	$1028.6
Number of Providers Terminated or Suspended	414	207

[1] Data reported in thousands of dollars.

Source: HCFA/OPPR, State Fraud and Abuse Reporting Form, Reporting Date March 24, 1978.

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